DEPARTMENT OF HEALTH AND HUMAN SERVICES **CENTERS FOR MEDICARE & MEDICAID SERVICES**

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: JXE8

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00096

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245271**
2.STATE VENDOR OR MEDICAID NO.
(L2) **797948100**

3. NAME AND ADDRESS OF FACILITY
(L3) **PROVIDENCE PLACE**
(L4) **3720 23RD AVENUE SOUTH**
(L5) **MINNEAPOLIS, MN** (L6) **55407**

4. TYPE OF ACTION: **7** (L8)
1. Initial 2. Recertification
3. Termination 4. CHOW
5. Validation 6. Complaint
7. On-Site Visit 9. Other
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9) **08/08/2007**

6. DATE OF SURVEY **02/09/2017** (L34)

8. ACCREDITATION STATUS: ___ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY **02** (L7)

01 Hospital	05 HHA	09 ESRD	13 PTIP	22 CLIA
02 SNF/NF/Dual	06 PRTF	10 NF	14 CORF	
03 SNF/NF/Distinct	07 X-Ray	11 ICF/IID	15 ASC	
04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	

FISCAL YEAR ENDING DATE: (L35)
09/30

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

12.Total Facility Beds **190** (L18)
13.Total Certified Beds **190** (L17)

10.THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC
X B. Not in Compliance with Program Requirements and/or Applied Waivers:

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
___ 6. Scope of Services Limit
___ 7. Medical Director
___ 8. Patient Room Size
___ 9. Beds/Room

* Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	190			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Sandra Tatro, HFE NEII 02/23/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Enforcement Specialist 04/17/2017 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
X 1. Facility is Eligible to Participate
___ 2. Facility is not Eligible
(L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :

22. ORIGINAL DATE OF PARTICIPATION
05/29/1984
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions:
(L44)
B. Rescind Suspension Date:
(L45)

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
01/31/2017
(L33)

DETERMINATION APPROVAL

C&T REMARKS - CMS 1539 FORM **STATE AGENCY REMARKS**

CCN: 24 5271

Sections 1819(h)(2)(D) and (E) and 1919(h)(2)(C) and (D) of the Act and 42 CFR 488.417(b) require that, regardless of any other remedies that may be imposed, denial of payment for new admissions must be imposed when a facility is not in substantial compliance 3 months after the last day of the survey identifying noncompliance.

As of our notice of February 17, 2017, deficiencies issued pursuant to the December 8, 2016 survey had not yet been verified. Thus, the CMS Region V Office concurred, and imposed the following remedy and authorized this Department to notify the facility of the imposition:

- Mandatory denial of payment for new Medicare and Medicaid admissions (DPNA), effective March 8, 2017.

If DPNA goes into effect the facility would be subject to a two year loss of NATCEP, beginning March 8, 2017.

On February 9, 2017, the Minnesota Department of Health completed a PCR to verify that the facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to the December 8, 2016 survey. We presumed, based on their plan of correction, that the facility had corrected these deficiencies as of January 17, 2017. Based on our visit, we have determined that the facility has not obtained substantial compliance with the deficiencies issued pursuant to our December 8, 2016 survey. The most serious deficiencies in the facility were found to be isolated deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level D). As a result of the revisit findings, the Department imposed the Category 1 remedy of State monitoring.

In addition, we recommended the following enforcement action related to the remedies in our letter of February 17, 2017:

- Mandatory denial of payment for new Medicare and Medicaid admissions (DPNA), effective March 8, 2017, remain in effect.

Refer to the CMS 2567 along with the plan of correction and CMS 2567b. Post Certification Revisit (PCR) to follow.

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
February 23, 2017

Mr. Tyler Donahue, Administrator
Providence Place
3720 23rd Avenue South
Minneapolis, Minnesota 55407

RE: Project Number S5271028

Dear Mr. Donahue:

On February 17, 2017, as authorized by the Centers for Medicare and Medicaid Services (CMS), the Department informed you that the following enforcement remedies was being imposed:

- Mandatory denial of payment for new Medicare and Medicaid admissions effective March 8, 2017. (42 CFR 488.417 (b))

In addition, the Department notified you in our letter of February 17, 2017, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from March 8, 2017.

This was based on the deficiencies cited by this Department for a standard survey completed on December 8, 2016, and lack of verification of substantial compliance with deficiencies issued pursuant to the standard survey, as of our February 17, 2017 letter. The survey found the most seroius deficiencies to be a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E), whereby corrections were required.

On February 9, 2017, the Minnesota Department of Health completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to the standard survey, completed on December 8, 2016. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of January 17, 2017. Based on our visit, we have determined that your facility has not obtained substantial compliance with the deficiencies issued pursuant to our PCR, completed on February 9, 2017. The deficiencies not corrected are as follows:

F0314 -- S/S: D -- 483.25(b)(1) -- Treatment/svcs To Prevent/heal Pressure Sores
F0356 -- S/S: C -- 483.35(g)(1)-(4) -- Posted Nurse Staffing Information
F0431 -- S/S: E -- 483.45(b)(2)(3)(g)(h) -- Drug Records, Label/store Drugs & Biologicals

In addition, at the time of this revisit, we identified the following deficiencies:

F0282 -- S/S: D -- 483.21(b)(3)(ii) -- Services By Qualified Persons/per Care Plan
F0312 -- S/S: D -- 483.24(a)(2) -- Adl Care Provided For Dependent Residents

The most serious deficiencies in your facility were found to be isolated deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level D), as evidenced by the attached CMS-2567, whereby corrections are required.

As a result of the revisit findings, the Department is imposing the following Category 1 remedy:

- State Monitoring effective February 28, 2017. (42 CFR 488.422)

In addition, the Department is recommending to the CMS Region V Office the following action as it related to the remedies imposed in our letter of February 15, 2017:

- Mandatory denial of payment for new Medicare and Medicaid admissions effective March 8, 2017, remain in effect. (42 CFR 488.417 (b))

As we notified you in our letter of February 15, 2017, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from March 8, 2017.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

DEPARTMENT CONTACT

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies (those preceded by a "F" tag), i.e., the plan of correction should be directed to:

Gail Anderson, Unit Supervisor
Fergus Falls Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health

Email: gail.anderson@state.mn.us
Phone: (218) 332-5140 Fax: (218) 332-5196

ELECTRONIC PLAN OF CORRECTION (ePoC)

An ePoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your ePoC must:

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;

- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;

- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;

- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;

- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,

- Submit electronically to acknowledge your receipt of the electronic 2567, your review and your ePoC submission..

The state agency may, in lieu of a revisit, determine correction and compliance by accepting the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

If an acceptable ePoC is not received within 10 calendar days from the receipt of this letter, we will recommend to the CMS Region V Office that one or more of the following remedies be imposed:

- Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));

- Per day civil money penalty (42 CFR 488.430 through 488.444).

Failure to submit an acceptable ePoC could also result in the termination of your facility's Medicare and/or Medicaid agreement.

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC and CMS Region V Office approval, a revisit of your facility may be conducted to verify that substantial compliance with the regulations has been attained. The revisit would occur after the date you identified that compliance was achieved in your plan of correction.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and we will recommend that the remedies imposed be discontinued effective the date of the on-site verification. Compliance is certified as of the date of the third revisit.

FAILURE TO ACHIEVE SUBSTANTIAL COMPLIANCE BY THE SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by June 8, 2017 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

In accordance with 42 CFR 488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:

Nursing Home Informal Dispute Process
Minnesota Department of Health
Health Regulation Division
P.O. Box 64900
St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm

Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

Feel free to contact me if you have questions related to this eNotice.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health

Email: mark.meath@state.mn.us
Telephone: (651) 201-4118
Fax: (651) 215-9697

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245271	A. BUILDING _____ B. WING _____	R 02/09/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROVIDENCE PLACE	**3720 23RD AVENUE SOUTH MINNEAPOLIS, MN 55407**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 000}	INITIAL COMMENTS An on-site resurvey was conducted by surveyors of this department 2/9/17, to determine compliance with Federal deficiencies issued during a recertification survey exited on 12/8/16. During this visit the following regulations were determined to be not corrected which are dilineated on the electronically delivered CMS 2567. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	{F 000}		
F 282 SS=D	483.21(b)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN (b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (ii) Be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to follow the individualized care plan for repositioning and toileting for 2 of 3 residents (R56, R114) whose	F 282	The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor agreement by the	3/3/17

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 02/24/2017

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245271	A. BUILDING _____ B. WING _____	R 02/09/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROVIDENCE PLACE	**3720 23RD AVENUE SOUTH MINNEAPOLIS, MN 55407**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 282	Continued From page 1 repositioning was observed. Findings include: R114's care plan revised 1/25/17, indicated a performance deficit in activities of daily living (ADL's), potential for pressure ulcers related to impaired cognition and dementia. R114 required assistance from two staff for repositioning every two hours, dressing, transferring with a Hoyer lift (a mechanical full body lift) and assistance to move to all destinations. Staff interventions included encouraging R114 to offload (relieve pressure to skin) every hour and encourage to turn and reposition at least every two hours. R114 also had bowel and bladder incontinence related to impaired cognition and dementia. R114 required assistance from two staff for incontinence care and was transferred using a Hoyer lift (a mechanical full body lift) and assistance to move to all destinations. Interventions directed staff to toilet R114 as soon as possible when finished with a meal and check every two hours for incontinence. R114 was continuously observed on 2/9/17, from 8:25 a.m. to 11:08 a.m. At 8:25 a.m. R114 was up for the day and was in the dining room for breakfast. R114 was seated in a gerichair with a Hoyer sling was underneath the resident. At 8:49 a.m. R114 was wheeled out of the dining room and into the television (TV) room by nursing assistant (NA)-A. R114 informed NA-A that he wanted to instead return to his room. NA-A replied, "Your room floor is wet and I will take you there when it's dry." NA-A continued assisting residents out of the dining room to the TV room. Trained medication assistant (TMA)-A was in the TV room passing medication to residents. R114's	F 282	facility of the truth of the facts alleged on conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by provisions of State and Federal law. Without waiving the foregoing statement, the facility states that: 1. Resident #56 expired. Resident #114 will have their comprehensive skin assessment and continence evaluation reviewed and updated to ensure accuracy. Care plans will be reviewed and updated as needed to reflect any change. NAR assignment sheets will also be reviewed and updated as needed with any changes. 2. All residents residing at the facility will have their comprehensive skin assessments and continence evaluation reviewed and updated to ensure accuracy. Care plans will be reviewed and updated as needed to reflect any change. NAR assignment sheets will be reviewed and updated as needed with any changes. Comprehensive skin assessments and continence evaluations will be reviewed quarterly, annually, and with significant changes. 3. All nursing staff will receive re education regarding process documentation for completion of the comprehensive skin assessment and continence evaluation. 4. DNS or designee will complete random weekly audits x1 month then monthly audits x2 months to ensure staff compliance with residents plan of care in regards to their toileting and repositioning	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245271	A. BUILDING _____ B. WING _____	R 02/09/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROVIDENCE PLACE	**3720 23RD AVENUE SOUTH MINNEAPOLIS, MN 55407**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 282	Continued From page 2 chair was titled back very slightly to approximately 5-10 degrees. R114 continued to yell out "No one helps me! I want to go to the bathroom!" At 8:58 a.m. (NA)-C was assisting another resident to the TV room and passed by R114 as he yelled, "I have to go to the bathroom." A minute later NA-A and NA-B stopped to ask R114, "What do you need?" R114 replied, "I want to go to the bathroom." NA-A informed R114 they were going to assist the rest of the residents out of the dining room, and then would take him to his room. At 9:09 a.m. R114 was mumbling, "I have to go to the bathroom" when he suddenly tipped his head back looking straight at the ceiling and shouted, "I have to go to the bathroom! No one cares! I have to go to the bathroom really bad!" Although TMA-A and the assistant director of nursing (ADON)-A were in the room, neither assisted or sought help for R114. Each time a staff person entered the TV room R114 informed them he needed to use the bathroom. At 9:24 a.m. R114 remained in the TV room when his hand started moving uncontrollably. At 9:27 a.m. therapeutic recreation (TR)-A entered the TV room to start a music program. R114 was still looking up at the ceiling with his hand moving when TR-A asked him if he was okay, and did he want to lie down or stay up in his chair. R114 reported to TR-A he was having pain. TR-A informed TMA-A and ADON-A "[R114] is having pain in his groin," however, neither TMA-A or ADON-A checked on R114. At 10:10 a.m. R114 had his head/neck tipped back, his eyes were closed, and his mouth open. At 10:22 a.m. NA-C talked to R114 and tried but was unable to assist the resident to get his foot tray to stay up, and then walked away. At 10:34 a.m. R114's tremors were on both sides of his body and his arms were shaking. R114 remained in the same position. At 10:56 a.m.	F 282	schedules. 5. Audit results and the data collected will be presented to the QAPI committee monthly by the DNS or designee. QAPI committee will review and make any necessary recommendations.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245271	A. BUILDING _____ B. WING _____	R 02/09/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROVIDENCE PLACE	**3720 23RD AVENUE SOUTH MINNEAPOLIS, MN 55407**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 282	Continued From page 3	F 282		

R114 continued having tremors and was looking up at the ceiling as staff came and went from the area. None of the staff offered to assist him to reposition.

NA-A was interviewed on 2/9/17, at 11:00 a.m. and stated he had assisted R114 up that day and to the dining room at around 7:30 a.m. NA-A explained R114 was totally dependent on staff for cares, required a Hoyer lift for transferring, and had a pressure ulcer on his coccyx. NA-A verified R114's Hoyer sling was left underneath him because, "If we try to removed it he will fight with us." NA-A reported he was aware R114 was supposed to be off loaded and repositioned every two hours and explained, "We change him before breakfast and when we lie him down after breakfast." When it was brought to NA-A's attention R114 had been observed without repositioning for over two and one half hours NA-A verified he had not been repositioned and stated, "Yes--we were going to do that now."

R114 was then assisted to his room at 11:08 a.m. While NA-A and NA-B assisted R114 to bed using the Hoyer lift, there was a foul odor of incontinent stool. R114's incontinent brief was removed and a very large soft stool was observed in his brief. NA-A reported R114's brief was also slightly wet with urine. In addition, R114 had a healed pressure ulcer around his buttocks that was slightly reddened around the area, but was blanchable. His scrotum was bright red in color. NA-A explained R114's scrotum was usually red and added, "This is the best I have seen it." R114 received incontinence care and was assisted back to the gerichair with the sling underneath him and was brought to the dining room for lunch.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245271	A. BUILDING _____ B. WING _____	R 02/09/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROVIDENCE PLACE	**3720 23RD AVENUE SOUTH MINNEAPOLIS, MN 55407**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 282	Continued From page 4 During an interview on 2/9/17, at 11:35 a.m. licensed practical nurse (LPN)-A verified staff was expected to follow R114's care plan and provide every two hour repositioning. LPN-A stated R114's pressure ulcer on the left buttock "healed yesterday--We are not putting any dressing on it just open to air and to watch to make sure it doesn't reopen." R56's 12/21/15, care plan indicated the resident had a potential for pressure ulcer development related to incontinence of bowel and bladder and a history of pressure ulcer on the hip. Interventions directed staff to check and change the resident using a mechanical lift, utilize barrier cream, document and report any changes in skin to the physician including the stage and description of any wounds. R56 was incontinent and was to be toileted every 2-3 hours or as needed. R56 was observed continuously on 2/9/17, from 8:25 a.m. to 11:08 a.m. At 8:25 a.m. R56 was seated in a gerichair on a Hoyer sling. R56 was eating breakfast, and at 9:03 a.m. he finished eating breakfast and was wheeled out of the dining room into the TV room. At 9:08 a.m. R56 had head down and eyes closed. At 9:27 a.m. the therapeutic recreation staff (TR)-A came into the TV room to hold a music program. At 9:40 a.m. the music program started, and R56 remained with his head down and eyes closed. At 10:11 R56 opened his eyes for a few minutes, and then closed his eyes again, with his body leaned to the left side. At 10:23 a.m. TR-B held another activity in the TV room until 10:43 a.m. and R56 remained in the same position throughout the activity. At 11:31 a.m. R56 remained in the same place and position in the TV room.	F 282		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245271	A. BUILDING _____ B. WING _____	R 02/09/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROVIDENCE PLACE	**3720 23RD AVENUE SOUTH MINNEAPOLIS, MN 55407**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 282	Continued From page 5	F 282		

During an interview on 2/9/17, at 11:39 a.m. NA-B stated she was responsible for providing care for R56 that morning, assisted him out of bed at around 7:40 or 8:00 a.m. NA-B explained after breakfast she repositioned the resident. NA-B explained she usually checked R56 every three hours for incontinence, and she usually checked him after he finished eating lunch. When NA-B was informed it had been more than three hours since R56 was assisted to use the toilet or had his brief changed, she did not reply. She then asked R56 if he needed to use the bathroom to which the resident replied "no." NA-B asked if she could check his brief, and R56 was assisted to his room. NA-B explained he required the use of a Hoyer lift for transfers and stated, "We always leave his Hoyer sling under him because it hard to take it on and off." Although R56's brief was dry, he had loose stool between the folds of his buttocks. The incontinence brief also had a yellowish spot of drainage from an open circular area on R56's buttock.

During an interview on 2/9/17, at 11:35 a.m. LPN-A verified R56 should have been offered toileting and been repositioned every 2-3 hours per his care plan. LPN-A said she was unaware R56 had an open area, but would need to check on it.

Later that day at 2:03 p.m. ADON-A stated she expected staff reposition and toilet residents according to their care plans.

During an interview on 2/9/17, at 3:13 p.m. physical therapist (PT)-A and certified occupational therapist assistant (COTA)-A stated if a resident was seated in a gerichair and was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245271	A. BUILDING _____ B. WING _____	R 02/09/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROVIDENCE PLACE	**3720 23RD AVENUE SOUTH MINNEAPOLIS, MN 55407**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 282	Continued From page 6 only tipped back at an approximate 5-10 degree angle. it would not constitute offloading pressure or repositioning. A care plan policy was requested, but was not received.	F 282		
F 312 SS=D	483.24(a)(2) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS (a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide timely assistance with toileting for 2 of 3 residents (R114, R56) observed for toileting. Findings include: R114 was continuously observed on 2/9/17, from 8:25 a.m. to 11:08 a.m. At 8:25 a.m. R114 was up for the day and was in the dining room for breakfast. At 8:49 a.m. R114 was wheeled out of the dining room and into the television (TV) room by nursing assistant (NA)-A. R114 informed NA-A that he wanted to instead return to his room. NA-A replied, "Your room floor is wet and I will take you there when it's dry." NA-A continued assisting residents out of the dining room to the TV room. Trained medication assistant (TMA)-A was in the TV room passing medication to residents as R114 continued to yell out "No one helps me! I want to go to the bathroom." At 8:58 a.m. (NA)-C was assisting another resident to the TV room and passed by R114 as he yelled, "I	F 312	The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by provisions of state and federal law. Without waiving the foregoing statement, the facility states that: 1. Resident #56 expired. Resident #114 will have their continence evaluation reviewed and updated to ensure accuracy. Care plans will be reviewed and updated as needed to reflect any change. NAR assignment sheets will also be reviewed and updated as needed with any changes. 2. All residents at the facility will have their continence evaluations reviewed and updated to ensure accuracy. Care plans	3/3/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245271	A. BUILDING _____ B. WING _____	R 02/09/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROVIDENCE PLACE	**3720 23RD AVENUE SOUTH MINNEAPOLIS, MN 55407**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 312	Continued From page 7 have to go to the bathroom." A minute later NA-A and NA-B stopped to ask R114, "What do you need?" R114 replied, "I want to go to the bathroom." NA-A informed R114 they were going to assist the rest of the residents out of the dining room, and then would take him to his room. At 9:09 a.m. R114 was mumbling, "I have to go to the bathroom" when he suddenly tipped his head back looking straight at the ceiling and shouted, "I have to go to the bathroom! No one cares! I have to go to the bathroom really bad!" Although TMA-A and the assistant director of nursing (ADON)-A were in the room, neither assisted or sought help for R114. Each time staff persons were in the TV room R114 informed them he needed to use the bathroom, however, he was not offered toileting or to have his brief changed. NA-A was interviewed on 2/9/17, at 11:00 a.m. and stated he had assisted R114 up that day and to the dining room at around 7:30 a.m. (approximately three and a half hours earlier). NA-A explained R114 was totally dependent on staff for cares, required a Hoyer lift for transferring, and was to be assisted with cares every two hours. NA-A explained, "We change him before breakfast and when we lie him down after breakfast." When it was brought to NA-A's attention R114 had been observed without cares for over two and one half hours NA-A verified he had not been repositioned and stated, "Yes--we were going to do that now." R114 was then assisted to his room at 11:08 a.m. While in his room he again asked to use the toilet. NA-A reported the resident would not have known if he was wet, but would be checked for incontinence. While NA-A and NA-B assisted R114 to bed using the Hoyer lift, there was a foul	F 312	will be reviewed and updated to ensure accuracy. Care plans will be reviewed and updated as needed with any significant changes. 3. All nursing staff will receive re-education regarding process and documentation for completion of the continence evaluation. 4. DNS or designee will complete random weekly audits x 1month then monthly audits x2 months to ensure staff compliance with residents plan of care in regards to their toileting schedules. 5. Audit results and the data collected will be presented to the QAPI committee monthly by the DNS or designee. QAPI committee will review and make any necessary recommendations.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245271	A. BUILDING _____ B. WING _____	R 02/09/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROVIDENCE PLACE	**3720 23RD AVENUE SOUTH MINNEAPOLIS, MN 55407**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 312	Continued From page 8	F 312		

odor of incontinent stool. R114's incontinent brief was removed and a very large soft stool was observed in his brief. R114 received incontinence care and was assisted back to the gerichair.

A 1/13/17, significant change Minimum Data Set for R114 revealed the resident had severely impaired cognition, however, was able to clearly communicate and comprehend communication. He displayed occasional verbal and physical behaviors, but did not reject care. R114 was dependent upon staff for transferring and using the toilet, and was always incontinent of bowel.

R114's care plan revised 1/25/17, indicated a performance deficit in activities of daily living and had bowel incontinence related to impaired cognition and dementia. R114 required assistance from two staff for bowel care and was transferred using a Hoyer lift (a mechanical full body lift) and assistance to move to all destinations. Interventions directed staff to toilet R114 as soon as possible when finished with a meal and check every two hours for incontinence.

During an interview on 2/9/17, at 11:35 a.m. licensed practical nurse (LPN)-A verified R114 was to be checked and changed every two hours and staff was expected to follow R114's care plan.

R56 was observed continuously on 2/9/17, from 8:25 a.m. to 11:08 a.m. At 8:25 a.m. R56 was seated in a gerichair on a Hoyer sling. R56 was eating breakfast, and at 9:03 a.m. he finished eating breakfast and was wheeled out of the dining room into the TV room. At 9:08 a.m. R56 had head down and eyes closed. At 9:27 a.m. the therapeutic recreation staff (TR)-A came into the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245271	A. BUILDING _____ B. WING _____	R 02/09/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROVIDENCE PLACE	**3720 23RD AVENUE SOUTH MINNEAPOLIS, MN 55407**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 312	Continued From page 9	F 312		

TV room to hold a music program. At 9:40 a.m. the music program started, and R56 remained with his head down and eyes closed. At 10:11 R56 opened his eyes for a few minutes, and then closed his eyes again, with his body leaned to the left side. At 10:23 a.m. TR-B held another activity in the TV room until 10:43 a.m. and R56 remained in the same position throughout the activity. At 11:31 a.m. R56 remained in the same place and position in the TV room.

R56's 12/1/15, indicated the resident had bowel incontinence, and was to be assisted with toileting every 2-3 hours and as needed. The 12/21/15, activities of daily living care plan indicated R56 was to be toileted with a brief change in bed.

During an interview on 2/9/17, at 11:39 a.m. NA-B stated she was responsible for providing care for R56 that morning, and had assisted him out of bed at around 7:40 or 8:00 a.m. NA-B explained after breakfast he had been repositioned, but she had not checked his incontinence brief. NA-B explained she usually checked R56 every three hours for incontinence, and usually after lunch. When NA-B was informed it had been more than three hours since R56 was assisted to use the toilet or had his brief changed, she did not reply. She then asked R56 if he needed to use the bathroom to which the resident replied "no." NA-B asked if she could check his brief, and R56 was assisted to his room. NA-B explained he required the use of a Hoyer lift for transfers. Although R56's brief was dry, he had loose stool between the folds of his buttocks.

During an interview on 2/9/17, at 11:35 a.m. LPN-A verified R56 should have been offered toileting and been checked for incontinence every

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245271	A. BUILDING _____ B. WING _____	R 02/09/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROVIDENCE PLACE	**3720 23RD AVENUE SOUTH MINNEAPOLIS, MN 55407**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 312	Continued From page 10 two to three hours per his care plan. Later that day at 2:03 p.m. the ADON-A stated she expected staff to ensure residents were toileted according to their care plans. A policy and procedure was requested, but was not provided.	F 312		
{F 314} SS=D	483.25(b)(1) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES (b) Skin Integrity - (1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide repositioning to minimize the risk for reoccurrence or further development of pressure ulcers for 2 of 3 residents (R114) reviewed for pressure ulcers. Findings include:	{F 314}	The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed	3/3/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245271	A. BUILDING _____ B. WING _____	R 02/09/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROVIDENCE PLACE	**3720 23RD AVENUE SOUTH MINNEAPOLIS, MN 55407**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 314}	Continued From page 11 R114 was continuously observed on 2/9/17, from 8:25 a.m. to 11:08 a.m. At 8:25 a.m. R114 was up for the day and was in the dining room for breakfast. R114 was seated in a gerichair with a Hoyer sling was underneath the resident. At 8:49 a.m. R114 was wheeled out of the dining room and into the television (TV) room by nursing assistant (NA)-A. R114 informed NA-A that he wanted to instead return to his room. NA-A replied, "Your room floor is wet and I will take you there when it's dry." NA-A continued assisting residents out of the dining room to the TV room. Trained medication assistant (TMA)-A was in the TV room passing medication to residents. R114's chair was titled back very slightly to approximately 5-10 degrees. R114 continued to yell out "No one helps me! I want to go to the bathroom!" At 8:58 a.m. (NA)-C was assisting another resident to the TV room and passed by R114 as he yelled, "I have to go to the bathroom." A minute later NA-A and NA-B stopped to ask R114, "What do you need?" R114 replied, "I want to go to the bathroom." NA-A informed R114 they were going to assist the rest of the residents out of the dining room, and then would take him to his room. At 9:09 a.m. R114 was mumbling, "I have to go to the bathroom" when he suddenly tipped his head back looking straight at the ceiling and shouted, "I have to go to the bathroom! No one cares! I have to go to the bathroom really bad!" Although TMA-A and the assistant director of nursing (ADON)-A were in the room, neither assisted or sought help for R114. Each time a staff person entered the TV room R114 informed them he needed to use the bathroom. At 9:24 a.m. R114 remained in the TV room when his hand started moving uncontrollably. At 9:27 a.m. therapeutic recreation (TR)-A entered the TV room to start a music program. R114 was still looking up at the	{F 314}	solely because it is required by provisions of state and federal law. Without waiving the foregoing statement, the facility states that. 1. Resident #56 expired. Resident # 114 will have their comprehensive skin assessment reviewed and updated to ensure accuracy. Care plans will be reviewed and updated as needed to reflect any change. NAR assignment sheets will also be reviewed and updated as needed with any changes. 2. All residents residing at the facility will have their comprehensive skin assessments reviewed and updated to ensure accuracy. Care plans will be reviewed and updated as needed to reflect any change. NAR assignment sheets will be reviewed and updated as needed with any changes. Comprehensive skin assessments will be reviewed quarterly, annually, and with significant changes. 3. All nursing staff will receive re-education regarding process and documentation for completion of the comprehensive skin assessment. 4. DNS or designee will complete random weekly audits x1 month then audits x2 months to ensure staff compliance with residents plan of care in regards to their repositioning schedules. 5. Audit results and the data collected will be presented to the QAPI committee monthly by the dns or designee. QAPI committee will review and make any necessary recommendations.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245271	A. BUILDING _____ B. WING _____	R 02/09/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROVIDENCE PLACE	**3720 23RD AVENUE SOUTH MINNEAPOLIS, MN 55407**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 314}	Continued From page 12	{F 314}		

ceiling with his hand moving when TR-A asked him if he was okay, and did he want to lie down or stay up in his chair. R114 reported to TR-A he was having pain. TR-A informed TMA-A and ADON-A "[R114] is having pain in his groin," however, neither TMA-A or ADON-A checked on R114. At 10:10 a.m. R114 had his head/neck tipped back, his eyes were closed, and his mouth open. At 10:22 a.m. NA-C talked to R114 and tried but was unable to assist the resident to get his foot tray to stay up, and then walked away. At 10:34 a.m. R114's tremors were on both sides of his body and his arms were shaking. R114 remained in the same position. At 10:56 a.m. R114 continued having tremors and was looking up at the ceiling as staff came and went from the area. None of the staff offered to assist him to reposition.

A 1/13/17, significant change Minimum Data Set for R114 revealed the resident had severely impaired cognition, however, was able to clearly communicate and comprehend communication. He displayed occasional verbal and physical behaviors, but did not reject care. R114 was dependent upon staff for transferring and using the toilet, and was always incontinent of bowel and bladder. He had diagnoses including arthritis, dementia and depression. The resident was at risk for pressure ulcer development, and at the time of the assessment he had one stage I or greater and one unstageable pressure ulcer, and utilized pressure relieving devices in both the chair and bed. He experienced frequent mild pain.

R114's care plan revised 1/25/17, indicated a performance deficit in activities of daily living (ADL's), potential for pressure ulcers related to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245271	A. BUILDING _____ B. WING _____	R 02/09/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROVIDENCE PLACE	**3720 23RD AVENUE SOUTH MINNEAPOLIS, MN 55407**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 314}	Continued From page 13	{F 314}		

impaired cognition and dementia. R114 required assistance from two staff for repositioning every two hours, dressing, transferring with a Hoyer lift (a mechanical full body lift) and assistance to move to all destinations. Staff interventions included encouraging R114 to offload (relieve pressure to skin) every hour and encourage to turn and reposition at least every two hours.

NA-A was interviewed on 2/9/17, at 11:00 a.m. and stated he had assisted R114 up that day and to the dining room at around 7:30 a.m. NA-A explained R114 was totally dependent on staff for cares, required a Hoyer lift for transferring, and had a pressure ulcer on his coccyx. NA-A verified R114's Hoyer sling was left underneath him because, "If we try to removed it he will fight with us." NA-A reported he was aware R114 was supposed to be off loaded and repositioned every two hours and explained, "We change him before breakfast and when we lie him down after breakfast." When it was brought to NA-A's attention R114 had been observed without repositioning for over two and one half hours NA-A verified he had not been repositioned and stated, "Yes--we were going to do that now."

R114 was then assisted to his room at 11:08 a.m. While NA-A and NA-B assisted R114 to bed using the Hoyer lift, there was a foul odor of incontinent stool. R114's incontinent brief was removed and a very large soft stool was observed in his brief. NA-A reported R114's brief was also slightly wet with urine. In addition, R114 had a healed pressure ulcer around his buttocks that was slightly reddened around the area, but was blanchable. His scrotum was bright red in color. NA-A explained R114's scrotum was usually red and added, "This is the best I have seen it." R114

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245271	A. BUILDING _____ B. WING _____	R 02/09/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROVIDENCE PLACE	**3720 23RD AVENUE SOUTH MINNEAPOLIS, MN 55407**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 314}	Continued From page 14	{F 314}		

received incontinence care and was assisted back to the gerichair with the sling underneath him and was brought to the dining room for lunch.

R114's wound summary revealed two recently healed pressure ulcers. 1) left ischial tuberosity documented on 1/31/17 and 2/8/17, as intact skin =100%; 2) left buttock documented on 1/25, 1/31 and 2/8/17, as intact skin=100%.

During an interview on 2/9/17, at 11:35 a.m. licensed practical nurse (LPN)-A verified staff was expected to follow R114's care plan and provide every two hour repositioning. LPN-A stated R114's pressure ulcer on the left buttock "healed yesterday--We are not putting any dressing on it just open to air and to watch to make sure it doesn't reopen."

R56 was observed continuously on 2/9/17, from 8:25 a.m. to 11:08 a.m. At 8:25 a.m. R56 was seated in a gerichair on a Hoyer sling. R56 was eating breakfast, and at 9:03 a.m. he finished eating breakfast and was wheeled out of the dining room into the TV room. At 9:08 a.m. R56 had head down and eyes closed. At 9:27 a.m. the therapeutic recreation staff (TR)-A came into the TV room to hold a music program. At 9:40 a.m. the music program started, and R56 remained with his head down and eyes closed. At 10:11 R56 opened his eyes for a few minutes, and then closed his eyes again, with his body leaned to the left side. At 10:23 a.m. TR-B held another activity in the TV room until 10:43 a.m. and R56 remained in the same position throughout the activity. At 11:31 a.m. R56 remained in the same place and position in the TV room.

R56's 9/18/14, care plan indicated the resident

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245271	A. BUILDING _____ B. WING _____	R 02/09/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROVIDENCE PLACE	**3720 23RD AVENUE SOUTH MINNEAPOLIS, MN 55407**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 314}	Continued From page 15	{F 314}		

had a potential for pressure ulcer development related to incontinence of bowel and bladder and a history of pressure ulcer on the hip. Interventions directed staff to check and change the resident every two hours using a mechanical lift, utilize barrier cream, document and report any changes in skin to the physician including the stage and description of any wounds.

During an interview on 2/9/17, at 11:39 a.m. NA-B stated she was responsible for providing care for R56 that morning, assisted him out of bed at around 7:40 or 8:00 a.m. NA-B explained after breakfast she repositioned the resident. NA-B explained she usually checked R56 every three hours for incontinence, and she usually checked him after he finished eating lunch. When NA-B was informed it had been more than three hours since R56 was assisted to use the toilet or had his brief changed, she did not reply. She then asked R56 if he needed to use the bathroom to which the resident replied "no." NA-B asked if she could check his brief, and R56 was assisted to his room. NA-B explained he required the use of a Hoyer lift for transfers and stated, "We always leave his Hoyer sling under him because it hard to take it on and off." Although R56's brief was dry, he had loose stool between the folds of his buttocks. The incontinence brief also had a yellowish spot of drainage from an open circular area on R56's buttock.

During an interview on 2/9/17, at 11:35 a.m. LPN-A verified R56 should have been offered toileting and been repositioned every 2-3 hours per his care plan. LPN-A said she was unaware R56 had an open area, but would need to check on it.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245271	A. BUILDING _____ B. WING _____	R 02/09/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROVIDENCE PLACE	**3720 23RD AVENUE SOUTH MINNEAPOLIS, MN 55407**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 314}	Continued From page 16 Later that day at 2:03 p.m. ADON-A stated she expected staff reposition and toilet residents according to their care plans. During an interview on 2/9/17, at 3:13 p.m. physical therapist (PT)-A and certified occupational therapist assistant (COTA)-A stated if a resident was seated in a gerichair and was only tipped back at an approximate 5-10 degree angle. it would not constitute offloading pressure or repositioning. The facility's 9/10, Providence Place Pressure Prevention Program Policy and Procedure directed staff to monitor the effectiveness of the pressure ulcer prevention program to reduce the development and progression of pressure ulcers, monitor the incidence and prevalence of pressure ulcers within the facility, and monitor adherences to policies and procedures for consistency in application and conformance with the current standards of practice.	{F 314}		
{F 356} SS=C	483.35(g)(1)-(4) POSTED NURSE STAFFING INFORMATION 483.35 (g) Nurse Staffing Information (1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift:	{F 356}		3/3/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245271	A. BUILDING _____ B. WING _____	R 02/09/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROVIDENCE PLACE	**3720 23RD AVENUE SOUTH MINNEAPOLIS, MN 55407**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 356}	Continued From page 17 (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law) (C) Certified nurse aides. (iv) Resident census. (2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. (3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. (4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to post nursing hours at the beginning of the shift as required. This had the potential to affect all 163 residents residing in	{F 356}	The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245271	A. BUILDING _____ B. WING _____	R 02/09/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROVIDENCE PLACE	**3720 23RD AVENUE SOUTH MINNEAPOLIS, MN 55407**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 356}	Continued From page 18 the facility and visitors. Findings include: The posted Nursing Hours Posting (NHP) for public display on 2/9/17, at 7:30 a.m. was dated the previous day 2/8/17, with a census of 163 residents. On 2/9/17, at 1:44 p.m. the posted NHP for public display was dated 2/9/17, with a census of 165. In an interview with the director of nursing (DON) at 3:36 p.m. on 2/9/17, the DON explained the staffing person who arrived at work between 8:00-8:30 a.m. went to each nursing station to verify staff who were not present, overtime hours, and the daily census. The DON stated the beginning of the day shift was 6:30 a.m. and the beginning of the evening shift was 2:30 p.m. and the facility policy was to post the NHP at 10:00 a.m. each morning. Additionally, a morning meeting was held at 9:00 a.m. at which gave the staff a better understanding of admissions, discharges and bed holds for the day. On the weekends the weekend supervisor was responsible for posting the NHP at 10:00 a.m. At 4:57 p.m. the DON explained the facility had decided to post the NHP once daily at 10:00 a.m. The facility's 5/16, policy for posting musing hours indicated the purpose was "To post nursing hours that is accessible for resident and/or family review...The information will be posted on a daily basis and updated with changes for each shift."	{F 356}	facility of the truth of the facts alleged on conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by provisions of state and federal law. Without waiving the foregoing statement, the facility states that: 1. Daily nursing hours were posted on 2/9/2017 prior to survey exit. 2. The policy and procedure for the posting of nursing hours was reviewed to ensure regulatory compliance. 3. Education was completed with the staffing coordinator and building supervisors regarding the policy and procedure for the daily nursing hours postings. 4. ED or designee will complete random weekly audits x1 month then monthly audits x 2months to ensure staff compliance with daily nursing hours posting. 5. Audit results and the data collected will be presented to the QAPI committee monthly by the ED or designee. QAPI committee will review and make any necessary recommendations.	
{F 431} SS=E	483.45(b)(2)(3)(g)(h) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must provide routine and emergency	{F 431}		3/3/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245271	A. BUILDING _____ B. WING _____	R 02/09/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROVIDENCE PLACE	**3720 23RD AVENUE SOUTH MINNEAPOLIS, MN 55407**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 431}	Continued From page 19	{F 431}		

drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.

(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.

(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who--

(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and

(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.

(g) Labeling of Drugs and Biologicals.
Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.

(h) Storage of Drugs and Biologicals.
(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245271	A. BUILDING _____ B. WING _____	R 02/09/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROVIDENCE PLACE	**3720 23RD AVENUE SOUTH MINNEAPOLIS, MN 55407**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 431}	Continued From page 20 have access to the keys. (2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to properly label, store and/or dispose medications with shortened expiration dates for 11 residents (R99, R39, R7, R5, R32, R228, R97, R4, R204, R24, R59) in 4 of 6 medication carts on 4 of 4 units reviewed for medication storage. Findings include: On 2/9/17, at 9:30 a.m. registered nurse (RN)-A stated, "We are to date eye drops, inhalers and insulins upon opening." RN-A stated she usually worked on the transitional care unit, but that day was assigned to work on the 2 north (N) unit. R99's hfa aerosol inhaler pharmacy label was crossed out in black marker, with only the resident's last name visible though the black mark on the label. RN-A stated someone had "scratched off" the other pertinent information. R99's (order date 2/2/17) physician orders directed staff to administer "Albuterol Sulfate HFA Aerosol Solution...1 puff inhale orally every 4 hours as needed for Dx_COPD [diagnoses of Chronic Obstructive Pulmonary Disease] 1-2	{F 431}	The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor agreement by the facility of the truth of the facts alleged on conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by provisions of state and federal law. Without waiving the foregoing statement, the facility states that: 1. pharmacy was consulted and identified medication carts were audited. Expired and/or undated medications were disposed of and replacement medications ordered as needed. 2. All medication carts were audited and any undated or expired medications were disposed of and replaced as needed. 3. A process was developed for periodic inspections of the medication carts that includes ensuring medications are dated when opened as required and expired medications are removed. 4. ED or designee will complete random	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245271	A. BUILDING _____ B. WING _____	R 02/09/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROVIDENCE PLACE	**3720 23RD AVENUE SOUTH MINNEAPOLIS, MN 55407**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 431}	Continued From page 21 puffs." RN-D reported on 2/9/17, at 9:46 a.m. the facility's guidelines for medication expiration were posted on the bulletin board at the nursing station. RN-B explained on 2/9/17. at 10:39 a.m. that she was working on call and had not worked on the 3N medication cart since the previous week, but verified the label issues on the medication cart. R39's opened eye drops Timolol Maleate were not dated when opened. The eye drops had approximately 1/2 remaining, and the pharmacy label indicated "1/04/17." RN-B said she was taught to label medications with shortened expiration dates upon opening; if medications were not labeled when opened, the nurse was to assume the opened date was the pharmacy date, therefore, R39's eye drops should have been considered expired 30 days later, on 2/4/17. RN-B stated she planned to discard the Timolol Maleate as it had expired and then would order a new one. R39's physician orders included "Timolol Maleate Solution 0.5% Instill 1 drop in both eyes as needed for, two times daily," ordered 1/4/17. R39's physician orders also indicated a diagnosis of unspecified glaucoma. R39's face sheet noted an admission date for R39 of 1/4/17. R7's bottle of Xalatan was opened, but was not labeled when opened. The bottle was less than half full and the pharmacy label date was 1/26/17. RN-B stated she could not tell when the bottle had been opened without an opened date, but had to then assume it was opened on 1/26/17, when it arrived from the pharmacy. RN-B stated	{F 431}	weekly audits x1 month then monthly audits x2 months to ensure staff compliance with medication cart inspections. 5. Audit results and the data collected will be presented to the QAPI committee monthly by the ED or designee. QAPI committee will review and make any necessary recommendations.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245271	A. BUILDING _____ B. WING _____	R 02/09/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROVIDENCE PLACE	**3720 23RD AVENUE SOUTH MINNEAPOLIS, MN 55407**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 431}	Continued From page 22	{F 431}		

she planned to date the bottle as expired on 3/9/17, as Xalatan was only good for 42 days after opening. R7's current physician orders indicated "Latanoprost Solution [Xalatan] 0.005% Instill 1 drop in left eye at bedtime for glaucoma" order dated 6/10/16.

On 2/9/17, at 11:37 a.m. trained medication assistant (TMA)-A on 3 south (3S) unit said staff was to check the expiration dates when opening eye drops and to date eye drops and inhalers when opened.

R5's bottle of Latanoprost was opened, and was undated with just under half remaining. TMA-A verified the finding, as well as responsibility for administering eye drops, and knew they were viable for 30 days. Since R5's eye drops had not been labeled when opened, TMA-A was unsure how long they should have been kept. TMA-A stated physician's orders on the medication administration record directed the number of days to administer eye drops," So I know the eye drops are good for that order." R5's current physician orders indicated "Latanoprost Solution 0.005% Instill 1 drop in both eyes at bedtime related to primary open-angle glaucoma" order dated 5/13/14.

On 2/9/17, at 12:21 p.m. TMA-B stated she administered eye drops and inhalers and was to date eye drops and inhalers upon opening.

R32's discus Advair was opened, undated and 35 puffs remained. TMA-B verified the Advair label indicated the Advair had been refilled on 1/16/17, and stated, "Advair lasts for 30 days after opened--the sheet says 30 days."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245271	A. BUILDING _____ B. WING _____	R 02/09/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROVIDENCE PLACE	**3720 23RD AVENUE SOUTH MINNEAPOLIS, MN 55407**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 431}	Continued From page 23 R228's inhaler Symbicort Ver was opened, undated with 118 puffs remaining. The refill date indicated on the label was 2/6/17, and TMA-B dated the inhaler 2/6/17. A Medication Storage And Expiration Guidelines sheet indicated Symbicort expired three months after the first use. R228's current physician orders indicated, "Budesonide-Formoterol Fumarate Aerolsol [Symbicort] 160-4.5 mcg/Act 2 puff inhale orally two times a day" for COPD, order dated 12/30/16. R97's bottle of Timolol Mal Sol was opened, dated 12/30/16. The bottle was empty and TMA-B stated, "Someone probably forgot to throw it away." TMA-B stated she had administered eye drops to R97 that morning, and there was another bottle of eye drops labeled with R97's name. TMA-B then located the second bottle that had been opened but was not dated when opened. TMA-B stated, "I will date this bottle today, the day I talked to you." After asking TMA-B when the bottle of eye drops had been delivered from the pharmacy, and said the label indicated 1/28/17. TMA-B then said she would instead date the bottle 1/28/17 versus 2/9/17. R97's current physician orders indicated, "Timolol Solution 0.5% (Timolol Maleate) Instill 1 drop in both eyes two times a day for dry eye" order dated 5/17/16. R97's 2/17, MAR indicated R97 had been receiving Timolol Solution 0.5% twice daily, at 8:00 a.m. and 8:00 p.m. On 2/9/17, at 2:21 p.m. TMA-C stated she could administer eye drops and inhalers and stated the staff, "Technically should date eye drops and inhalers upon opening." TMA-C stated some eye drops were only effective a recommended 30-60 days, when they would not be considered to have a potency level.	{F 431}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245271	A. BUILDING _____ B. WING _____	R 02/09/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROVIDENCE PLACE	**3720 23RD AVENUE SOUTH MINNEAPOLIS, MN 55407**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 431}	Continued From page 24 On 2/9/17, at 2:27 p.m. licensed practical nurse (LPN)-B reviewed the 2S medication cart with the surveyor. LPN-B stated shortened time frame inhalers and eye drops were supposed to be dated when opened, because they had shorter and different times to dispose of than the expiration dates on the medication. LPN-B stated other medications did not have to be dated, and they could use the manufacturer's expiration dates. R4's bottle of eye drops Xalatan was opened, undated and slightly over half full with a pharmacy date on the label of 12/22/16. LPN-B reported using the pharmacy date which meant R4's eye drops would have expired 2/2/17. LPN-B stated, "I am going to destroy the bottle and reorder from the pharmacy." R4's current physician orders dated 12/8/16, directed "Xalatan Solution 0.005% [Latanoprost] Instill 1 drop in right eye at bedtime for chronic conjunctivitis." R4's 2/17, MAR indicated R4 had been receiving Xalatan Solution 0.005% eye drops each evening at 8:00 p.m. from 2/1 to 2/8/17, (six days past the expiration date). While peeling the reorder label off R4's bottle of eye drops, however, the surveyor noticed the bottle was labeled with the R204's name versus R4's name. LPN-B stated it was just the reorder label that had the wrong resident's name, and not the bottle. R204's current physician orders active as of 1/23/17, directed staff to administer Systane Ultra Solution 0.4-0.3% eye drops for dry eyes. R24's bottle of eye drops Xalatan was opened, undated, approximately one fifth full, and had a pharmacy date of 12/6/16. LPN-B stated the eye	{F 431}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245271	A. BUILDING _____ B. WING _____	R 02/09/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROVIDENCE PLACE	**3720 23RD AVENUE SOUTH MINNEAPOLIS, MN 55407**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 431}	Continued From page 25	{F 431}		

drops would have expired 1/17/17, and stated, "I am going to destroy and reorder." LPN-B verified second bottle of Xalatan for R24 was opened, undated, and more than half full and "pharmacy refill 1/7/17 exp [expires] 2/18/17." R24's current physician orders indicated, "Xalatan Solution 0.005% Instill 1 drop in both eyes at bedtime related to unspecified glaucoma" order dated 8/26/16. R24's 2/17, MAR indicated R24 had been receiving Xalatan Solution 0.005% 1 drop in both eyes at bedtime related to unspecified glaucoma daily 2/1 to 2/8/17, (past the 1/17/17 expiration date).

R59's bottle of eye drops Xalatan was opened, undated, and was over half full with a pharmacy refill date "exp 2/21/17" which was verified by LPN-B. R59's 2/17, MAR indicated R59 had been receiving Latanoprost 0.005% eye drops nightly in both eyes at bedtime for glaucoma in 2/17 (order date 4/14/16).

On 2/9/17, at 2:46 p.m. TMA-C stated typically the TMAs administered more of the medications, inhalers, and eye drops, and the nurses administered insulin. TMA-C stated she did not know who opened the Xalatan eye drops, but said, "probably a night or evening nurse....If I saw an undated, opened eye drops I would go by the pharmacy date [on the label] and know when it was sent."

The director of nursing (DON) stated on 2/9/17, at 3:18 p.m. eye drops and inhalers on the Medication Storage And Expiration Guidelines were dated upon opening because they had a shorter time frame to use than the expiration date. The DON stated she would talk to the consulting pharmacist (CP) about medications

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245271	A. BUILDING _____ B. WING _____	R 02/09/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROVIDENCE PLACE	**3720 23RD AVENUE SOUTH MINNEAPOLIS, MN 55407**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 431}	Continued From page 26 with shortened time frames. At 3:26 p.m. the DON reported she talked to the CP. The CP informed her Xalatan eye drops were viable for 42 days after opening. Although there was no harm from using the product itself, using the drops after that date resulted in potential for not receiving optimal disease control. The DON stated she had educated all nurses and TMAs regarding dating medications with shortened expiration dates following the last survey, and had competed audits of the facility's medication storage system. The facility provided 8/15, Medication Storage And Expiration Guidelines that indicated medication Symbicort inhalers were to be dated when opened, and expired three months after 1st use; Advair Discus was to be dated when opened, and expired 30 days after foil opened; Xalatan eye drops were to be dated when opened, and expired 42 days after 1st use; and Timolol Maleate eye drops were to be dated when opened, and expired one month after opened. The same guidelines also indicated, "Specified medications found undated when opened will be presumed to have been opened as of the date of dispensing."	{F 431}		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION A. Building B. Wing (Y2)	DATE OF REVISIT (Y3)
245271		2/9/2017

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
PROVIDENCE PLACE	3720 23RD AVENUE SOUTH MINNEAPOLIS, MN 55407

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0280 Reg. # 483.10(c)(2)(i-ii,iv,v)(3),483.21(b)(2) LSC	Correction Completed 02/09/2017	ID Prefix F0412 Reg. # 483.55(b)(1)(2)(5) LSC	Correction Completed 02/09/2017	ID Prefix F0441 Reg. # 483.80(a)(1)(2)(4)(e)(f) LSC	Correction Completed 02/09/2017
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY [x]	**REVIEWED BY (INITIALS)** GL/mm	**DATE** 02/23/2017	**SIGNATURE OF SURVEYOR** 34086	**DATE** 02/09/2017
REVIEWED BY CMS RO [ ]	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**
FOLLOWUP TO SURVEY COMPLETED ON 12/8/2016	[ ] CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? [ ] **YES** [ ] **NO**			

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
February 15, 2017

Mr. Tyler Donahue, Administrator
Providence Place
3720 23rd Avenue South
Minneapolis, Minnesota 55407

RE: Project Number S5271028

Dear Mr. Donahue:

On December 27, 2016, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on December 8, 2016. This survey found the most serious deficiencies to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D), whereby corrections were required.

We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of January 17, 2017. However, compliance with the health deficiencies issued pursuant to the December 8, 2016 standard survey has not yet been verified. The most serious health deficiencies in your facility at the time of the standard survey were found to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D), whereby corrections were required.

Sections 1819(h)(2)(D) and (E) and 1919(h)(2)(C) and (D) of the Act and 42 CFR 488.417(b) require that, regardless of any other remedies that may be imposed, denial of payment for new admissions must be imposed when the facility is not in substantial compliance 3 months after the last day of the survey identifying noncompliance. Thus, the CMS Region V Office concurs, is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Mandatory Denial of payment for new Medicare and Medicaid admissions effective March 8, 2017. (42 CFR 488.417 (b))

The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new admissions is effective March 8, 2017. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective March 8, 2017. You should notify all Medicare/Medicaid residents admitted on or after this date of the restriction.

Further, Federal law, as specified in the Act at Sections 1819(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to a denial of payment. Therefore, Providence Place is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Programs or Competency Evaluation Programs for two years effective

March 8, 2017. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions. If this prohibition is not rescinded, under Public Law 105-15 (H.R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

APPEAL RIGHTS

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

Tamika.Brown@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
(202) 565-9462

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Tamika Brown, Principal Program Representative by phone at (312) 353-1502 or by e-mail at Tamika.Brown@cms.hhs.gov .

FAILURE TO ACHIEVE SUBSTANTIAL COMPLIANCE BY THE SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by June 8, 2017 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

In accordance with 42 CFR 488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:

Nursing Home Informal Dispute Process
Minnesota Department of Health
Health Regulation Division
P.O. Box 64900
St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm

Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

Feel free to contact me if you have questions related to this eNotice.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Email: mark.meath@state.mn.us
Telephone: (651) 201-4118 Fax: (651) 215-9697

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00096	A. BUILDING: _____ B. WING _____	R 02/09/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROVIDENCE PLACE	3720 23RD AVENUE SOUTH MINNEAPOLIS, MN 55407

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{2 000}	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: An onsite follow-up visit was completed on 2/9/17. During this onsite visit it was determined all deficiencies were not corrected (see CMS 2567). The uncorrected orders will remain in effect and will be reviewed at the next onsite visit, and will be reviewed for possible penalty assessments.	{2 000}		

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 02/24/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00096	A. BUILDING: _____ B. WING _____	R 02/09/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROVIDENCE PLACE	3720 23RD AVENUE SOUTH MINNEAPOLIS, MN 55407

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 565	MN Rule 4658.0405 Subp. 3 Comprehensive Plan of Care; Use Subp. 3. Use. A comprehensive plan of care must be used by all personnel involved in the care of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to follow the individualized care plan for repositioning and toileting for 2 of 3 residents (R56, R114) whose repositioning was observed. Findings include: R114's care plan revised 1/25/17, indicated a performance deficit in activities of daily living (ADL's), potential for pressure ulcers related to impaired cognition and dementia. R114 required assistance from two staff for repositioning every two hours, dressing, transferring with a Hoyer lift (a mechanical full body lift) and assistance to move to all destinations. Staff interventions included encouraging R114 to offload (relieve pressure to skin) every hour and encourage to turn and reposition at least every two hours. R114 also had bowel and bladder incontinence related to impaired cognition and dementia. R114 required assistance from two staff for incontinence care and was transferred using a Hoyer lift (a mechanical full body lift) and assistance to move to all destinations. Interventions directed staff to toilet R114 as soon as possible when finished with a meal and check every two hours for incontinence.	2 565	acknowledged.	3/3/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00096	A. BUILDING: _____ B. WING _____	R 02/09/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROVIDENCE PLACE	3720 23RD AVENUE SOUTH MINNEAPOLIS, MN 55407

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 565	Continued From page 2 R114 was continuously observed on 2/9/17, from 8:25 a.m. to 11:08 a.m. At 8:25 a.m. R114 was up for the day and was in the dining room for breakfast. R114 was seated in a gerichair with a Hoyer sling was underneath the resident. At 8:49 a.m. R114 was wheeled out of the dining room and into the television (TV) room by nursing assistant (NA)-A. R114 informed NA-A that he wanted to instead return to his room. NA-A replied, "Your room floor is wet and I will take you there when it's dry." NA-A continued assisting residents out of the dining room to the TV room. Trained medication assistant (TMA)-A was in the TV room passing medication to residents. R114's chair was titled back very slightly to approximately 5-10 degrees. R114 continued to yell out "No one helps me! I want to go to the bathroom!" At 8:58 a.m. (NA)-C was assisting another resident to the TV room and passed by R114 as he yelled, "I have to go to the bathroom." A minute later NA-A and NA-B stopped to ask R114, "What do you need?" R114 replied, "I want to go to the bathroom." NA-A informed R114 they were going to assist the rest of the residents out of the dining room, and then would take him to his room. At 9:09 a.m. R114 was mumbling, "I have to go to the bathroom" when he suddenly tipped his head back looking straight at the ceiling and shouted, "I have to go to the bathroom! No one cares! I have to go to the bathroom really bad!" Although TMA-A and the assistant director of nursing (ADON)-A were in the room, neither assisted or sought help for R114. Each time a staff person entered the TV room R114 informed them he needed to use the bathroom. At 9:24 a.m. R114 remained in the TV room when his hand started moving uncontrollably. At 9:27 a.m. therapeutic recreation (TR)-A entered the TV room to start a music program. R114 was still looking up at the	2 565		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00096	A. BUILDING: _____ B. WING _____	R 02/09/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROVIDENCE PLACE	3720 23RD AVENUE SOUTH MINNEAPOLIS, MN 55407

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 565	Continued From page 3	2 565		

ceiling with his hand moving when TR-A asked him if he was okay, and did he want to lie down or stay up in his chair. R114 reported to TR-A he was having pain. TR-A informed TMA-A and ADON-A "[R114] is having pain in his groin," however, neither TMA-A or ADON-A checked on R114. At 10:10 a.m. R114 had his head/neck tipped back, his eyes were closed, and his mouth open. At 10:22 a.m. NA-C talked to R114 and tried but was unable to assist the resident to get his foot tray to stay up, and then walked away. At 10:34 a.m. R114's tremors were on both sides of his body and his arms were shaking. R114 remained in the same position. At 10:56 a.m. R114 continued having tremors and was looking up at the ceiling as staff came and went from the area. None of the staff offered to assist him to reposition.

NA-A was interviewed on 2/9/17, at 11:00 a.m. and stated he had assisted R114 up that day and to the dining room at around 7:30 a.m. NA-A explained R114 was totally dependent on staff for cares, required a Hoyer lift for transferring, and had a pressure ulcer on his coccyx. NA-A verified R114's Hoyer sling was left underneath him because, "If we try to removed it he will fight with us." NA-A reported he was aware R114 was supposed to be off loaded and repositioned every two hours and explained, "We change him before breakfast and when we lie him down after breakfast." When it was brought to NA-A's attention R114 had been observed without repositioning for over two and one half hours NA-A verified he had not been repositioned and stated, "Yes--we were going to do that now."

R114 was then assisted to his room at 11:08 a.m. While NA-A and NA-B assisted R114 to bed using the Hoyer lift, there was a foul odor of incontinent

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00096	A. BUILDING: _____ B. WING _____	R 02/09/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROVIDENCE PLACE	3720 23RD AVENUE SOUTH MINNEAPOLIS, MN 55407

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 565	Continued From page 4	2 565		

stool. R114's incontinent brief was removed and a very large soft stool was observed in his brief. NA-A reported R114's brief was also slightly wet with urine. In addition, R114 had a healed pressure ulcer around his buttocks that was slightly reddened around the area, but was blanchable. His scrotum was bright red in color. NA-A explained R114's scrotum was usually red and added, "This is the best I have seen it." R114 received incontinence care and was assisted back to the gerichair with the sling underneath him and was brought to the dining room for lunch.

During an interview on 2/9/17, at 11:35 a.m. licensed practical nurse (LPN)-A verified staff was expected to follow R114's care plan and provide every two hour repositioning. LPN-A stated R114's pressure ulcer on the left buttock "healed yesterday--We are not putting any dressing on it just open to air and to watch to make sure it doesn't reopen."

R56's 12/21/15, care plan indicated the resident had a potential for pressure ulcer development related to incontinence of bowel and bladder and a history of pressure ulcer on the hip. Interventions directed staff to check and change the resident using a mechanical lift, utilize barrier cream, document and report any changes in skin to the physician including the stage and description of any wounds. R56 was incontinent and was to be toileted every 2-3 hours or as needed.

R56 was observed continuously on 2/9/17, from 8:25 a.m. to 11:08 a.m. At 8:25 a.m. R56 was seated in a gerichair on a Hoyer sling. R56 was eating breakfast, and at 9:03 a.m. he finished eating breakfast and was wheeled out of the dining room into the TV room. At 9:08 a.m. R56

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00096	A. BUILDING: _____ B. WING _____	R 02/09/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROVIDENCE PLACE	3720 23RD AVENUE SOUTH MINNEAPOLIS, MN 55407

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 565	Continued From page 5	2 565		

had head down and eyes closed. At 9:27 a.m. the therapeutic recreation staff (TR)-A came into the TV room to hold a music program. At 9:40 a.m. the music program started, and R56 remained with his head down and eyes closed. At 10:11 R56 opened his eyes for a few minutes, and then closed his eyes again, with his body leaned to the left side. At 10:23 a.m. TR-B held another activity in the TV room until 10:43 a.m. and R56 remained in the same position throughout the activity. At 11:31 a.m. R56 remained in the same place and position in the TV room.

During an interview on 2/9/17, at 11:39 a.m. NA-B stated she was responsible for providing care for R56 that morning, assisted him out of bed at around 7:40 or 8:00 a.m. NA-B explained after breakfast she repositioned the resident. NA-B explained she usually checked R56 every three hours for incontinence, and she usually checked him after he finished eating lunch. When NA-B was informed it had been more than three hours since R56 was assisted to use the toilet or had his brief changed, she did not reply. She then asked R56 if he needed to use the bathroom to which the resident replied "no." NA-B asked if she could check his brief, and R56 was assisted to his room. NA-B explained he required the use of a Hoyer lift for transfers and stated, "We always leave his Hoyer sling under him because it hard to take it on and off." Although R56's brief was dry, he had loose stool between the folds of his buttocks. The incontinence brief also had a yellowish spot of drainage from an open circular area on R56's buttock.

During an interview on 2/9/17, at 11:35 a.m. LPN-A verified R56 should have been offered toileting and been repositioned every 2-3 hours per his care plan. LPN-A said she was unaware

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00096	A. BUILDING: _____ B. WING _____	R 02/09/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROVIDENCE PLACE	3720 23RD AVENUE SOUTH MINNEAPOLIS, MN 55407

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 565	Continued From page 6 R56 had an open area, but would need to check on it. Later that day at 2:03 p.m. ADON-A stated she expected staff reposition and toilet residents according to their care plans. During an interview on 2/9/17, at 3:13 p.m. physical therapist (PT)-A and certified occupational therapist assistant (COTA)-A stated if a resident was seated in a gerichair and was only tipped back at an approximate 5-10 degree angle. it would not constitute offloading pressure or repositioning. A care plan policy was requested, but was not received.	2 565		
{2 905}	MN Rule 4658.0525 Subp. 4 Rehab - Positioning Subp. 4. Positioning. Residents must be positioned in good body alignment. The position of residents unable to change their own position must be changed at least every two hours, including periods of time after the resident has been put to bed for the night, unless the physician has documented that repositioning every two hours during this time period is unnecessary or the physician has ordered a different interval. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide repositioning to minimize the risk for reoccurrence or further development of pressure ulcers for 2 of 3 residents (R114) reviewed for pressure ulcers.	{2 905}	acknowledged	3/3/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00096	A. BUILDING: _____ B. WING _____	R 02/09/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROVIDENCE PLACE	3720 23RD AVENUE SOUTH MINNEAPOLIS, MN 55407

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{2 905}	Continued From page 7 Findings include: R114 was continuously observed on 2/9/17, from 8:25 a.m. to 11:08 a.m. At 8:25 a.m. R114 was up for the day and was in the dining room for breakfast. R114 was seated in a gerichair with a Hoyer sling was underneath the resident. At 8:49 a.m. R114 was wheeled out of the dining room and into the television (TV) room by nursing assistant (NA)-A. R114 informed NA-A that he wanted to instead return to his room. NA-A replied, "Your room floor is wet and I will take you there when it's dry." NA-A continued assisting residents out of the dining room to the TV room. Trained medication assistant (TMA)-A was in the TV room passing medication to residents. R114's chair was titled back very slightly to approximately 5-10 degrees. R114 continued to yell out "No one helps me! I want to go to the bathroom!" At 8:58 a.m. (NA)-C was assisting another resident to the TV room and passed by R114 as he yelled, "I have to go to the bathroom." A minute later NA-A and NA-B stopped to ask R114, "What do you need?" R114 replied, "I want to go to the bathroom." NA-A informed R114 they were going to assist the rest of the residents out of the dining room, and then would take him to his room. At 9:09 a.m. R114 was mumbling, "I have to go to the bathroom" when he suddenly tipped his head back looking straight at the ceiling and shouted, "I have to go to the bathroom! No one cares! I have to go to the bathroom really bad!" Although TMA-A and the assistant director of nursing (ADON)-A were in the room, neither assisted or sought help for R114. Each time a staff person entered the TV room R114 informed them he needed to use the bathroom. At 9:24 a.m. R114 remained in the TV room when his hand started moving uncontrollably. At 9:27 a.m. therapeutic recreation (TR)-A entered the TV room to start a	{2 905}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00096	A. BUILDING: _____ B. WING _____	R 02/09/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROVIDENCE PLACE	3720 23RD AVENUE SOUTH MINNEAPOLIS, MN 55407

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{2 905}	Continued From page 8	{2 905}		

music program. R114 was still looking up at the ceiling with his hand moving when TR-A asked him if he was okay, and did he want to lie down or stay up in his chair. R114 reported to TR-A he was having pain. TR-A informed TMA-A and ADON-A "[R114] is having pain in his groin," however, neither TMA-A or ADON-A checked on R114. At 10:10 a.m. R114 had his head/neck tipped back, his eyes were closed, and his mouth open. At 10:22 a.m. NA-C talked to R114 and tried but was unable to assist the resident to get his foot tray to stay up, and then walked away. At 10:34 a.m. R114's tremors were on both sides of his body and his arms were shaking. R114 remained in the same position. At 10:56 a.m. R114 continued having tremors and was looking up at the ceiling as staff came and went from the area. None of the staff offered to assist him to reposition.

A 1/13/17, significant change Minimum Data Set for R114 revealed the resident had severely impaired cognition, however, was able to clearly communicate and comprehend communication. He displayed occasional verbal and physical behaviors, but did not reject care. R114 was dependent upon staff for transferring and using the toilet, and was always incontinent of bowel and bladder. He had diagnoses including arthritis, dementia and depression. The resident was at risk for pressure ulcer development, and at the time of the assessment he had one stage I or greater and one unstageable pressure ulcer, and utilized pressure relieving devices in both the chair and bed. He experienced frequent mild pain.

R114's care plan revised 1/25/17, indicated a performance deficit in activities of daily living (ADL's), potential for pressure ulcers related to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00096	A. BUILDING: _____ B. WING _____	R 02/09/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROVIDENCE PLACE	3720 23RD AVENUE SOUTH MINNEAPOLIS, MN 55407

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{2 905}	Continued From page 9	{2 905}		

impaired cognition and dementia. R114 required assistance from two staff for repositioning every two hours, dressing, transferring with a Hoyer lift (a mechanical full body lift) and assistance to move to all destinations. Staff interventions included encouraging R114 to offload (relieve pressure to skin) every hour and encourage to turn and reposition at least every two hours.

NA-A was interviewed on 2/9/17, at 11:00 a.m. and stated he had assisted R114 up that day and to the dining room at around 7:30 a.m. NA-A explained R114 was totally dependent on staff for cares, required a Hoyer lift for transferring, and had a pressure ulcer on his coccyx. NA-A verified R114's Hoyer sling was left underneath him because, "If we try to removed it he will fight with us." NA-A reported he was aware R114 was supposed to be off loaded and repositioned every two hours and explained, "We change him before breakfast and when we lie him down after breakfast." When it was brought to NA-A's attention R114 had been observed without repositioning for over two and one half hours NA-A verified he had not been repositioned and stated, "Yes--we were going to do that now."

R114 was then assisted to his room at 11:08 a.m. While NA-A and NA-B assisted R114 to bed using the Hoyer lift, there was a foul odor of incontinent stool. R114's incontinent brief was removed and a very large soft stool was observed in his brief. NA-A reported R114's brief was also slightly wet with urine. In addition, R114 had a healed pressure ulcer around his buttocks that was slightly reddened around the area, but was blanchable. His scrotum was bright red in color. NA-A explained R114's scrotum was usually red and added, "This is the best I have seen it." R114 received incontinence care and was assisted

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00096	A. BUILDING: _____ B. WING _____	R 02/09/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROVIDENCE PLACE	3720 23RD AVENUE SOUTH MINNEAPOLIS, MN 55407

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{2 905}	Continued From page 10 back to the gerichair with the sling underneath him and was brought to the dining room for lunch. R114's wound summary revealed two recently healed pressure ulcers. 1) left ischial tuberosity documented on 1/31/17 and 2/8/17, as intact skin =100%; 2) left buttock documented on 1/25, 1/31 and 2/8/17, as intact skin=100%. During an interview on 2/9/17, at 11:35 a.m. licensed practical nurse (LPN)-A verified staff was expected to follow R114's care plan and provide every two hour repositioning. LPN-A stated R114's pressure ulcer on the left buttock "healed yesterday--We are not putting any dressing on it just open to air and to watch to make sure it doesn't reopen." R56 was observed continuously on 2/9/17, from 8:25 a.m. to 11:08 a.m. At 8:25 a.m. R56 was seated in a gerichair on a Hoyer sling. R56 was eating breakfast, and at 9:03 a.m. he finished eating breakfast and was wheeled out of the dining room into the TV room. At 9:08 a.m. R56 had head down and eyes closed. At 9:27 a.m. the therapeutic recreation staff (TR)-A came into the TV room to hold a music program. At 9:40 a.m. the music program started, and R56 remained with his head down and eyes closed. At 10:11 R56 opened his eyes for a few minutes, and then closed his eyes again, with his body leaned to the left side. At 10:23 a.m. TR-B held another activity in the TV room until 10:43 a.m. and R56 remained in the same position throughout the activity. At 11:31 a.m. R56 remained in the same place and position in the TV room. R56's 9/18/14, care plan indicated the resident had a potential for pressure ulcer development related to incontinence of bowel and bladder and	{2 905}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00096	A. BUILDING: _____ B. WING _____	R 02/09/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROVIDENCE PLACE	3720 23RD AVENUE SOUTH MINNEAPOLIS, MN 55407

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{2 905}	Continued From page 11	{2 905}		

a history of pressure ulcer on the hip. Interventions directed staff to check and change the resident every two hours using a mechanical lift, utilize barrier cream, document and report any changes in skin to the physician including the stage and description of any wounds.

During an interview on 2/9/17, at 11:39 a.m. NA-B stated she was responsible for providing care for R56 that morning, assisted him out of bed at around 7:40 or 8:00 a.m. NA-B explained after breakfast she repositioned the resident. NA-B explained she usually checked R56 every three hours for incontinence, and she usually checked him after he finished eating lunch. When NA-B was informed it had been more than three hours since R56 was assisted to use the toilet or had his brief changed, she did not reply. She then asked R56 if he needed to use the bathroom to which the resident replied "no." NA-B asked if she could check his brief, and R56 was assisted to his room. NA-B explained he required the use of a Hoyer lift for transfers and stated, "We always leave his Hoyer sling under him because it hard to take it on and off." Although R56's brief was dry, he had loose stool between the folds of his buttocks. The incontinence brief also had a yellowish spot of drainage from an open circular area on R56's buttock.

During an interview on 2/9/17, at 11:35 a.m. LPN-A verified R56 should have been offered toileting and been repositioned every 2-3 hours per his care plan. LPN-A said she was unaware R56 had an open area, but would need to check on it.

Later that day at 2:03 p.m. ADON-A stated she expected staff reposition and toilet residents according to their care plans.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00096	A. BUILDING: _____ B. WING _____	R 02/09/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROVIDENCE PLACE	3720 23RD AVENUE SOUTH MINNEAPOLIS, MN 55407

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{2 905}	Continued From page 12 During an interview on 2/9/17, at 3:13 p.m. physical therapist (PT)-A and certified occupational therapist assistant (COTA)-A stated if a resident was seated in a gerichair and was only tipped back at an approximate 5-10 degree angle. it would not constitute offloading pressure or repositioning. The facility's 9/10, Providence Place Pressure Prevention Program Policy and Procedure directed staff to monitor the effectiveness of the pressure ulcer prevention program to reduce the development and progression of pressure ulcers, monitor the incidence and prevalence of pressure ulcers within the facility, and monitor adherences to policies and procedures for consistency in application and conformance with the current standards of practice.	{2 905}		
2 920	MN Rule 4658.0525 Subp. 6 B Rehab - ADLs Subp. 6. Activities of daily living. Based on the comprehensive resident assessment, a nursing home must ensure that: B. a resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This MN Requirement is not met as evidenced by: F312	2 920	acknowleged	3/3/17
21620	MN Rule 4658.1345 Labeling of Drugs Drugs used in the nursing home must be labeled in accordance with part 6800.6300.	21620		3/3/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00096	A. BUILDING: _____ B. WING _____	R 02/09/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROVIDENCE PLACE	3720 23RD AVENUE SOUTH MINNEAPOLIS, MN 55407

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21620	Continued From page 13 This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to properly label, store and/or dispose medications with shortened expiration dates for 11 residents (R99, R39, R7, R5, R32, R228, R97, R4, R204, R24, R59) in 4 of 6 medication carts on 4 of 4 units reviewed for medication storage. Findings include: On 2/9/17, at 9:30 a.m. registered nurse (RN)-A stated, "We are to date eye drops, inhalers and insulins upon opening." RN-A stated she usually worked on the transitional care unit, but that day was assigned to work on the 2 north (N) unit. R99's hfa aerosol inhaler pharmacy label was crossed out in black marker, with only the resident's last name visible though the black mark on the label. RN-A stated someone had "scratched off" the other pertinent information. R99's (order date 2/2/17) physician orders directed staff to administer "Albuterol Sulfate HFA Aerosol Solution...1 puff inhale orally every 4 hours as needed for Dx_COPD [diagnoses of Chronic Obstructive Pulmonary Disease] 1-2 puffs." RN-D reported on 2/9/17, at 9:46 a.m. the facility's guidelines for medication expiration were posted on the bulletin board at the nursing station. RN-B explained on 2/9/17. at 10:39 a.m. that she was working on call and had not worked on the 3N medication cart since the previous week, but	21620	acknowledged	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00096	A. BUILDING: _____ B. WING _____	R 02/09/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROVIDENCE PLACE	3720 23RD AVENUE SOUTH MINNEAPOLIS, MN 55407

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21620	Continued From page 14 verified the label issues on the medication cart. R39's opened eye drops Timolol Maleate were not dated when opened. The eye drops had approximately 1/2 remaining, and the pharmacy label indicated "1/04/17." RN-B said she was taught to label medications with shortened expiration dates upon opening; if medications were not labeled when opened, the nurse was to assume the opened date was the pharmacy date, therefore, R39's eye drops should have been considered expired 30 days later, on 2/4/17. RN-B stated she planned to discard the Timolol Maleate as it had expired and then would order a new one. R39's physician orders included "Timolol Maleate Solution 0.5% Instill 1 drop in both eyes as needed for, two times daily," ordered 1/4/17. R39's physician orders also indicated a diagnosis of unspecified glaucoma. R39's face sheet noted an admission date for R39 of 1/4/17. R7's bottle of Xalatan was opened, but was not labeled when opened. The bottle was less than half full and the pharmacy label date was 1/26/17. RN-B stated she could not tell when the bottle had been opened without an opened date, but had to then assume it was opened on 1/26/17, when it arrived from the pharmacy. RN-B stated she planned to date the bottle as expired on 3/9/17, as Xalatan was only good for 42 days after opening. R7's current physician orders indicated "Latanoprost Solution [Xalatan] 0.005% Instill 1 drop in left eye at bedtime for glaucoma" order dated 6/10/16. On 2/9/17, at 11:37 a.m. trained medication assistant (TMA)-A on 3 south (3S) unit said staff was to check the expiration dates when opening eye drops and to date eye drops and inhalers	21620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00096	A. BUILDING: _____ B. WING _____	R 02/09/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROVIDENCE PLACE	3720 23RD AVENUE SOUTH MINNEAPOLIS, MN 55407

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21620	Continued From page 15 when opened. R5's bottle of Latanoprost was opened, and was undated with just under half remaining. TMA-A verified the finding, as well as responsibility for administering eye drops, and knew they were viable for 30 days. Since R5's eye drops had not been labeled when opened, TMA-A was unsure how long they should have been kept. TMA-A stated physician's orders on the medication administration record directed the number of days to administer eye drops," So I know the eye drops are good for that order." R5's current physician orders indicated "Latanoprost Solution 0.005% Instill 1 drop in both eyes at bedtime related to primary open-angle glaucoma" order dated 5/13/14. On 2/9/17, at 12:21 p.m. TMA-B stated she administered eye drops and inhalers and was to date eye drops and inhalers upon opening. R32's discus Advair was opened, undated and 35 puffs remained. TMA-B verified the Advair label indicated the Advair had been refilled on 1/16/17, and stated, "Advair lasts for 30 days after opened--the sheet says 30 days." R228's inhaler Symbicort Ver was opened, undated with 118 puffs remaining. The refill date indicated on the label was 2/6/17, and TMA-B dated the inhaler 2/6/17. A Medication Storage And Expiration Guidelines sheet indicated Symbicort expired three months after the first use. R228's current physician orders indicated, "Budesonide-Formoterol Fumarate Aerolsol [Symbicort] 160-4.5 mcg/Act 2 puff inhale orally two times a day" for COPD, order dated 12/30/16. R97's bottle of Timolol Mal Sol was opened,	21620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00096	A. BUILDING: _____ B. WING _____	R 02/09/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROVIDENCE PLACE	3720 23RD AVENUE SOUTH MINNEAPOLIS, MN 55407

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21620	Continued From page 16	21620		

dated 12/30/16. The bottle was empty and TMA-B stated, "Someone probably forgot to throw it away." TMA-B stated she had administered eye drops to R97 that morning, and there was another bottle of eye drops labeled with R97's name. TMA-B then located the second bottle that had been opened but was not dated when opened. TMA-B stated, "I will date this bottle today, the day I talked to you." After asking TMA-B when the bottle of eye drops had been delivered from the pharmacy, and said the label indicated 1/28/17. TMA-B then said she would instead date the bottle 1/28/17 versus 2/9/17. R97's current physician orders indicated, "Timolol Solution 0.5% (Timolol Maleate) Instill 1 drop in both eyes two times a day for dry eye" order dated 5/17/16. R97's 2/17, MAR indicated R97 had been receiving Timolol Solution 0.5% twice daily, at 8:00 a.m. and 8:00 p.m.

On 2/9/17, at 2:21 p.m. TMA-C stated she could administer eye drops and inhalers and stated the staff, "Technically should date eye drops and inhalers upon opening." TMA-C stated some eye drops were only effective a recommended 30-60 days, when they would not be considered to have a potency level.

On 2/9/17, at 2:27 p.m. licensed practical nurse (LPN)-B reviewed the 2S medication cart with the surveyor. LPN-B stated shortened time frame inhalers and eye drops were supposed to be dated when opened, because they had shorter and different times to dispose of than the expiration dates on the medication. LPN-B stated other medications did not have to be dated, and they could use the manufacturer's expiration dates.

R4's bottle of eye drops Xalatan was opened,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00096	A. BUILDING: _____ B. WING _____	R 02/09/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROVIDENCE PLACE	3720 23RD AVENUE SOUTH MINNEAPOLIS, MN 55407

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21620	Continued From page 17	21620		

undated and slightly over half full with a pharmacy date on the label of 12/22/16. LPN-B reported using the pharmacy date which meant R4's eye drops would have expired 2/2/17. LPN-B stated, "I am going to destroy the bottle and reorder from the pharmacy." R4's current physician orders dated 12/8/16, directed "Xalatan Solution 0.005% [Latanoprost] Instill 1 drop in right eye at bedtime for chronic conjunctivitis." R4's 2/17, MAR indicated R4 had been receiving Xalatan Solution 0.005% eye drops each evening at 8:00 p.m. from 2/1 to 2/8/17, (six days past the expiration date).

While peeling the reorder label off R4's bottle of eye drops, however, the surveyor noticed the bottle was labeled with the R204's name versus R4's name. LPN-B stated it was just the reorder label that had the wrong resident's name, and not the bottle. R204's current physician orders active as of 1/23/17, directed staff to administer Systane Ultra Solution 0.4-0.3% eye drops for dry eyes.

R24's bottle of eye drops Xalatan was opened, undated, approximately one fifth full, and had a pharmacy date of 12/6/16. LPN-B stated the eye drops would have expired 1/17/17, and stated, "I am going to destroy and reorder." LPN-B verified second bottle of Xalatan for R24 was opened, undated, and more than half full and "pharmacy refill 1/7/17 exp [expires] 2/18/17." R24's current physician orders indicated, "Xalatan Solution 0.005% Instill 1 drop in both eyes at bedtime related to unspecified glaucoma" order dated 8/26/16. R24's 2/17, MAR indicated R24 had been receiving Xalatan Solution 0.005% 1 drop in both eyes at bedtime related to unspecified glaucoma daily 2/1 to 2/8/17, (past the 1/17/17 expiration date).

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00096	A. BUILDING: _____ B. WING _____	R 02/09/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROVIDENCE PLACE	3720 23RD AVENUE SOUTH MINNEAPOLIS, MN 55407

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21620	Continued From page 18 R59's bottle of eye drops Xalatan was opened, undated, and was over half full with a pharmacy refill date "exp 2/21/17" which was verified by LPN-B. R59's 2/17, MAR indicated R59 had been receiving Latanoprost 0.005% eye drops nightly in both eyes at bedtime for glaucoma in 2/17 (order date 4/14/16). On 2/9/17, at 2:46 p.m. TMA-C stated typically the TMAs administered more of the medications, inhalers, and eye drops, and the nurses administered insulin. TMA-C stated she did not know who opened the Xalatan eye drops, but said, "probably a night or evening nurse....If I saw an undated, opened eye drops I would go by the pharmacy date [on the label] and know when it was sent." The director of nursing (DON) stated on 2/9/17, at 3:18 p.m. eye drops and inhalers on the Medication Storage And Expiration Guidelines were dated upon opening because they had a shorter time frame to use than the expiration date. The DON stated she would talk to the consulting pharmacist (CP) about medications with shortened time frames. At 3:26 p.m. the DON reported she talked to the CP. The CP informed her Xalatan eye drops were viable for 42 days after opening. Although there was no harm from using the product itself, using the drops after that date resulted in potential for not receiving optimal disease control. The DON stated she had educated all nurses and TMAs regarding dating medications with shortened expiration dates following the last survey, and had competed audits of the facility's medication storage system. The facility provided 8/15, Medication Storage And Expiration Guidelines that indicated	21620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00096	A. BUILDING: _____ B. WING _____	R 02/09/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROVIDENCE PLACE	**3720 23RD AVENUE SOUTH MINNEAPOLIS, MN 55407**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21620	Continued From page 19 medication Symbicort inhalers were to be dated when opened, and expired three months after 1st use; Advair Discus was to be dated when opened, and expired 30 days after foil opened; Xalatan eye drops were to be dated when opened, and expired 42 days after 1st use; and Timolol Maleate eye drops were to be dated when opened, and expired one month after opened. The same guidelines also indicated, "Specified medications found undated when opened will be presumed to have been opened as of the date of dispensing."	21620		

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
00096 Y1	A. Building B. Wing Y2	2/9/2017 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
PROVIDENCE PLACE	3720 23RD AVENUE SOUTH MINNEAPOLIS, MN 55407

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix 20570	Correction	ID Prefix 21335	Correction	ID Prefix 21375	Correction
Reg. # MN Rule 4658.0405 Subp. 4	Completed	Reg. # MN Rule 4658.0725 Subp. 3 A&B	Completed	Reg. # MN Rule 4658.0800 Subp. 1	Completed
LSC	02/09/2017	LSC	02/09/2017	LSC	02/09/2017
ID Prefix 21610	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # MN Rule 4658.1340 Subp. 1	Completed	Reg. #	Completed	Reg. #	Completed
LSC	02/09/2017	LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
☒	GL/mm	02/23/2017	34086	02/09/2017
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON
12/8/2016

☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ **YES** ☐ **NO**

DEPARTMENT OF HEALTH AND HUMAN SERVICES — **CENTERS FOR MEDICARE & MEDICAID SERVICES**

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: JXE8

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00096

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245271**
2.STATE VENDOR OR MEDICAID NO.
(L2) **797948100**

3. NAME AND ADDRESS OF FACILITY
(L3) **PROVIDENCE PLACE**
(L4) **3720 23RD AVENUE SOUTH**
(L5) **MINNEAPOLIS, MN** (L6) **55407**

4. TYPE OF ACTION: **2** (L8)
1. Initial 2. Recertification
3. Termination 4. CHOW
5. Validation 6. Complaint
7. On-Site Visit 9. Other
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9) **08/08/2007**

6. DATE OF SURVEY **12/08/2016** (L34)

8. ACCREDITATION STATUS: ___ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY **02** (L7)

01 Hospital	05 HHA	09 ESRD	13 PTIP	22 CLIA
02 SNF/NF/Dual	06 PRTF	10 NF	14 CORF	
03 SNF/NF/Distinct	07 X-Ray	11 ICF/IID	15 ASC	
04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	

FISCAL YEAR ENDING DATE: (L35)
09/30

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

12.Total Facility Beds **190** (L18)
13.Total Certified Beds **190** (L17)

10.THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements Compliance Based On:
___1. Acceptable POC
X B. Not in Compliance with Program Requirements and/or Applied Waivers:

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
___ 6. Scope of Services Limit
___ 7. Medical Director
___ 8. Patient Room Size
___ 9. Beds/Room

* Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	190			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):
See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Mary Bruess, HFE NEII 01/11/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Enforcement Specialist 01/30/2017 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
X 1. Facility is Eligible to Participate
___ 2. Facility is not Eligible
(L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :

22. ORIGINAL DATE OF PARTICIPATION
05/29/1984
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions:
(L44)
B. Rescind Suspension Date:
(L45)

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

C&T REMARKS - CMS 1539 FORM **STATE AGENCY REMARKS**

CCN: 24 5271

On December 8, 2016, a standard survey was completed at the facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation regulations. This survey found the most serious deficiencies in the facility to be a pattern of deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level E). In addition, at the time of the December 8, 2016 standard survey an investigation of complaint numbers H5271186 and H5271188 were conducted and found to be unsubstantiated. Refer to the CMS 2567 along with the facility's plan of correction for both health and life safety code. Post Certification Revisit (PCR) to follow.

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
December 27, 2016

Mr. Tyler D. Donahue, Administrator
Providence Place
3720 23rd Avenue South
Minneapolis, Minnesota 55407

RE: Project Number S5271028, H5271186 and H5271188

Dear Mr. Donahue:

On December 8, 2016, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs. This survey found the most serious deficiencies in your facility to be a pattern of deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level E), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed. In addition, at the time of the December 8, 2016 standard survey an investigation of complaint numbers H5271186 and H5271188 were conducted and found to be unsubstantiated.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

This letter provides important information regarding your response to these deficiencies and addresses the following issues:

Opportunity to Correct - the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;

Electronic Plan of Correction - when a plan of correction will be due and the information to be contained in that document;

Remedies - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not attained at the time of a revisit;

Potential Consequences - the consequences of not attaining substantial compliance 3 and 6 months after the survey date; and

Informal Dispute Resolution - your right to request an informal reconsideration to dispute the attached deficiencies.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

DEPARTMENT CONTACT

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies (those preceded by a "F" tag), i.e., the plan of correction should be directed to:

Gayle Lantto, Unit Supervisor
Metro D Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health

Email: gayle.lantto@state.mn.us
Phone: (651) 201-3794 Fax: (651) 215-9697

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by January 17, 2017, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

ELECTRONIC PLAN OF CORRECTION (ePoC)

An ePoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your ePoC must:

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;

- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;

- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;

- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;

- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,

- Submit electronically to acknowledge your receipt of the electronic 2567, your review and your ePoC submission.

The state agency may, in lieu of a revisit, determine correction and compliance by accepting the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

If an acceptable ePoC is not received within 10 calendar days from the receipt of this letter, we will recommend to the CMS Region V Office that one or more of the following remedies be imposed:

- Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));

- Per day civil money penalty (42 CFR 488.430 through 488.444).

Failure to submit an acceptable ePoC could also result in the termination of your facility's Medicare and/or Medicaid agreement.

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. A Post Certification Revisit (PCR) will occur after the date you identified that compliance was achieved in your plan of correction.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

Original deficiencies not corrected

If your facility has not achieved substantial compliance, we will impose the remedies described above. If the level of noncompliance worsened to a point where a higher category of remedy may be imposed, we will recommend to the CMS Region V Office that those other remedies be imposed.

Original deficiencies not corrected and new deficiencies found during the revisit

If new deficiencies are identified at the time of the revisit, those deficiencies may be disputed through the informal dispute resolution process. However, the remedies specified in this letter will be imposed for original deficiencies not corrected. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed.

Original deficiencies corrected but new deficiencies found during the revisit

If new deficiencies are found at the revisit, the remedies specified in this letter will be imposed. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed. You will be provided the required notice before the imposition of a new remedy or informed if another date will be set for the imposition of these remedies.

FAILURE TO ACHIEVE SUBSTANTIAL COMPLIANCE BY THE THIRD OR SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

If substantial compliance with the regulations is not verified by March 8, 2017 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the

result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by June 8, 2017 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

In accordance with 42 CFR 488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:

Nursing Home Informal Dispute Process
Minnesota Department of Health
Health Regulation Division
P.O. Box 64900
St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm

Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag), i.e., the plan of correction, request for waivers, should be directed to:

Mr. Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division

Email: tom.linhoff@state.mn.us
Telephone: (651) 430-3012
Fax: (651) 215-0525

Feel free to contact me if you have questions related to this eNotice.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health

Email: mark.meath@state.mn.us
Telephone: (651) 201-4118
Fax: (651) 215-9697

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245271	A. BUILDING _____ B. WING _____	C 12/08/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROVIDENCE PLACE	**3720 23RD AVENUE SOUTH MINNEAPOLIS, MN 55407**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. At the time of the Recertification survey, investigations were conducted into complaints H5271186 and H5271188. The complaints were not substantiated.	F 000		
F 280 SS=D	483.10(c)(2)(i-ii,iv,v)(3),483.21(b)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP 483.10 (c)(2) The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to: (i) The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care. (ii) The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care.	F 280		1/17/17

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 01/11/2017

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245271	A. BUILDING _____ B. WING _____	C 12/08/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROVIDENCE PLACE	**3720 23RD AVENUE SOUTH MINNEAPOLIS, MN 55407**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 280	Continued From page 1 (iv) The right to receive the services and/or items included in the plan of care. (v) The right to see the care plan, including the right to sign after significant changes to the plan of care. (c)(3) The facility shall inform the resident of the right to participate in his or her treatment and shall support the resident in this right. The planning process must-- (i) Facilitate the inclusion of the resident and/or resident representative. (ii) Include an assessment of the resident's strengths and needs. (iii) Incorporate the resident's personal and cultural preferences in developing goals of care. 483.21 (b) Comprehensive Care Plans (2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident.	F 280		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245271	A. BUILDING _____ B. WING _____	C 12/08/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROVIDENCE PLACE	**3720 23RD AVENUE SOUTH MINNEAPOLIS, MN 55407**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 280	Continued From page 2 (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide care and services to minimize the risk for further development of pressure ulcers for 1 of 2 residents (R149) reviewed with pressure ulcers. Findings include: R149's current care plan for R149 (revised on 2/12/14), indicated the resident had the potential for pressure ulcer development related to immobility, diabetes, incontinence, and sheering. Interventions included turning and repositioning at least every two hours, or more frequently as needed or requested.	F 280	The preparation of the following plan of correction for these deficiencies does not constitute and should not be interpreted as an admission nor an agreement be the facility of the truth of the facts alleged on conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required be provisions of state and federal law. Without waiving the foregoing statement, the facility states that with respect to; 1. Resident #149 was examined by podiatry on 12/12/16 with diagnosed non-pressure related wounds secondary to footwear irritation and poor circulation.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245271	A. BUILDING _____ B. WING _____	C 12/08/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROVIDENCE PLACE	**3720 23RD AVENUE SOUTH MINNEAPOLIS, MN 55407**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 280	Continued From page 3 R149 was observed continuously on 12/7/16, from 12:10 p.m. until 2:48 p.m. without repositioning. At 12:10 he was in a wheelchair in the dining room eating lunch. At 1:04 registered nurse (RN)-I assisted R149 to his room and performed a dressing change as ordered to both feet. At 1:20 an exercise activity was offered to the resident but was declined. At 1:22 RN-I left the room, and no repositioning in the wheelchair was offered or performed during the time RN-I was in R149's room. R149 remained seated in his wheelchair with his eyes closed from 1:28 until 1:53 when the resident's vital signs were taken; the resident was not repositioned. Nursing assistant (NA-C) asked R149 at 2:03 if he needed anything. When asked if he needed his incontinence brief changed or to use the toilet the resident denied being incontinent and replied, "Not now." Repositioning was not offered. At 2:38 RN-I stated there were only two NAs on the floor from 2:30 to 3:00. At 2:44 NA-A stated R149 was not in her "regular group" but she was "covering" for NA-B. NA-A stated staff was to offload R149 every two hours, but she was unable to state when R149 had last been repositioned explaining, "I would not know," and stated she did not get a report when she arrived on the unit. At 2:48 R149 remained in his wheelchair without repositioning. During a staff interview on 12/5/16, at 5:10 p.m. the registered nurse (RN-D) stated R149 had developed a pressure ulcer on each of his bilateral (both sides) great toes. She explained the pressure areas were due to edema in his lower extremities and feet which caused his shoes to become tight resulting in pressure, and were unstageable (could not be visualized). A Wound Summary Sheet dated 11/30/16, identified the cause of both the left and the right great toe	F 280	In addition to podiatry exam, a comprehensive skin and repositioning evaluation has been completed. Current wounds were entered into the wound rounds program for weekly monitoring and a braden assessment completed. R149 care plan has been revised to include measures for care, monitoring and treatment of the residents vascular wounds. The NAR assignment sheets have been revised to reflect the changes. 2. All residents with current wounds have had their care plans reviewed and revised as indicated to include all measures for prevention, treatment, care and monitoring of their current wound with revisions as indicated to reflect any changes. 3. All nursing staff will be re-educated regarding completing comprehensive skin risk assessment and accuracy of the Braden to determine risk. Education will be completed be Ed. Meaux of wound round. 4. All nurse leadership received wound round education on 12/14/16. 5. The director of nursing and/or designee will audit three residents each week for one month and then two residents per week for two months to assure the plan of care for the individual resident is appropriate for promoting healing and preventing further breakdown. 6. The data collected will be presented to the QAPI committee be the Director of Nursing. The data will be reviewed/discussed at the monthly quality meeting. At this time the committee will make the decision/recommendation	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245271	A. BUILDING _____ B. WING _____	C 12/08/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROVIDENCE PLACE	**3720 23RD AVENUE SOUTH MINNEAPOLIS, MN 55407**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 280	Continued From page 4 ulcers as pressure related and facility acquired. R149's most recent Care Assessment Area assessment dated 6/9/16, identified the resident was at risk for skin breakdown due to diagnosis of diabetes, lymphedema, incontinence of bowel and bladder, and immobility. The assessment further indicated R149 did not have skin breakdown at that time. R149's Comprehensive Skin and Positioning Evaluation dated 9/2/16, identified contributing skin factors for the resident including chair fast, skin often moist, very limited mobility, and potential problem for friction and sheer. R149's quarterly Minimum Data Set (MDS) dated 12/1/16, required extensive assistance of two staff for bed mobility and transfers. The MDS indicated the resident had two existing pressure ulcers on his feet. He had pressure relieving devices in the chair and bed, but did not have a turning and repositioning program. The Active [physician] Orders as of 11/25/16, directed staff to offload (relieve pressure by lifting or standing) from the wheelchair every two hours if the resident permitted (start date of 7/29/13). The current Treatment Administration Record directs staff to offload from wheelchair every hour if resident permitted. Weekly wound flow sheets for R149 were requested but not obtained. During a staff interview on 12/7/16, at 2:58 p.m. RN-D stated nursing assistants (NAs) were to report off to oncoming NAs at the end of their shift. She further stated there was no written policy or standardized report sheet used for this process. She further stated the NAs reported in	F 280	regarding any necessary follow up studies.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245271	A. BUILDING _____ B. WING _____	C 12/08/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROVIDENCE PLACE	**3720 23RD AVENUE SOUTH MINNEAPOLIS, MN 55407**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 280	Continued From page 5 Point of Care, but reflected the time it was documented versus the time the resident was repositioned. On 12/8/16, at 10:54 a.m. the director of nursing stated she expected staff to provide care to residents as directed in their care plans to meet the individual needs of the resident. The facility's 9/10, Providence Place Pressure Prevention Program Policy and Procedure directed staff to monitor the effectiveness of the pressure ulcer prevention program to reduce the development and progression of pressure ulcers, monitor the incidence and prevalence of pressure ulcers within the facility, and monitor adherences to policies and procedures for consistency in application and conformance with the current standards of practice.	F 280		
F 314 SS=D	483.25(b)(1) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES (b) Skin Integrity - (1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers	F 314		1/17/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245271	A. BUILDING _____ B. WING _____	C 12/08/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROVIDENCE PLACE	**3720 23RD AVENUE SOUTH MINNEAPOLIS, MN 55407**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 6 from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide care and services to minimize the risk for further development of pressure ulcers for 1 of 2 residents (R149) reviewed with pressure ulcers. Findings include: R149 was observed continuously on 12/7/16, from 12:10 p.m. until 2:48 p.m. without repositioning. At 12:10 he was in a wheelchair in the dining room eating lunch. At 1:04 registered nurse (RN)-I assisted R149 to his room and performed a dressing change as ordered to both feet. At 1:20 an exercise activity was offered to the resident but was declined. At 1:22 RN-I left the room, and no repositioning in the wheelchair was offered or performed during the time RN-I was in R149's room. R149 remained seated in his wheelchair with his eyes closed from 1:28 until 1:53 when the resident's vital signs were taken; the resident was not repositioned. Nursing assistant (NA-C) asked R149 at 2:03 if he needed anything. When asked if he needed his incontinence brief changed or to use the toilet the resident denied being incontinent and replied, "Not now." Repositioning was not offered. At 2:38 RN-I stated there were only two NAs on the floor from 2:30 to 3:00. At 2:44 NA-A stated R149 was not in her "regular group" but she was "covering" for NA-B. NA-A stated staff was to offload R149 every two hours, but she was unable to state when R149 had last been repositioned explaining, "I would not know," and stated she did not get a report when she arrived on the unit. At 2:48 R149 remained in his wheelchair without repositioning.	F 314	1. Resident #149 was examined by podiatry on 12/12/16 with diagnosed non-pressure related wounds secondary to foot wear irritation and poor circulation. In addition to podiatry exam, a comprehensive skin and repositioning evaluation has been completed. Current wounds were entered into the wound rounds program for weekly monitoring and a Braden Assessment completed. R149 care plan has been revised to include measures for care, monitoring, and treatment of the residents vascular wounds. The NAR assignment sheets have been revised to reflect the changes. 2. All residents with current wounds have had their care plans reviewed and revised as indicated to include all measures for prevention, treatment, care and monitoring of their current wound with revisions as indicated. The NAR assignment sheet has been revised as indicated to reflect any changes. 3. All nursing staff will be re-educated regarding completing the comprehensive skin risk assessment and accuracy of the Braden to determine risk. Education will be completed be Ed Meaux of wound rounds. All nurse leadership received education on 12/14/16. 4. The director of nursing/and or designee will audit three residents each week for one month and then two residents per week for two months to assure the plan of care for the individual resident is appropriate for promoting	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245271	A. BUILDING _____ B. WING _____	C 12/08/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROVIDENCE PLACE	**3720 23RD AVENUE SOUTH MINNEAPOLIS, MN 55407**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 7 During a staff interview on 12/5/16, at 5:10 p.m. the registered nurse (RN-D) stated R149 had developed a pressure ulcer on each of his bilateral (both sides) great toes. She explained the pressure areas were due to edema in his lower extremities and feet which caused his shoes to become tight resulting in pressure, and were unstageable (could not be visualized). A Wound Summary Sheet dated 11/30/16, identified the cause of both the left and the right great toe ulcers as pressure related and facility acquired. The current care plan for R149 (revised on 2/12/14), indicated the resident had the potential for pressure ulcer development related to immobility, diabetes, incontinence, and sheering. Interventions included turning and repositioning at least every two hours, or more frequently as needed or requested. R149's most recent Care Assessment Area assessment dated 6/9/16, identified the resident was at risk for skin breakdown due to diagnosis of diabetes, lymphedema, incontinence of bowel and bladder, and immobility. The assessment further indicated R149 did not have skin breakdown at that time. R149's Comprehensive Skin and Positioning Evaluation dated 9/2/16, identified contributing skin factors for the resident including chair fast, skin often moist, very limited mobility, and potential problem for friction and sheer. R149's quarterly Minimum Data Set (MDS) dated 12/1/16, required extensive assistance of two staff for bed mobility and transfers. The MDS indicated the resident had two existing pressure	F 314	healing and preventing further breakdown. 5. The data collected will be presented to the QAPI committee by the director of nursing. The data will be reviewed/discussed at the monthly Quality meeting. At this time the committee will make the decision/recommendation regarding any necessary follow up studies.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245271	A. BUILDING _____ B. WING _____	C 12/08/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROVIDENCE PLACE	**3720 23RD AVENUE SOUTH MINNEAPOLIS, MN 55407**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 8	F 314		

ulcers on his feet. He had pressure relieving devices in the chair and bed, but did not have a turning and repositioning program.

The Active [physician] Orders as of 11/25/16, directed staff to offload (relieve pressure by lifting or standing) from the wheelchair every two hours if the resident permitted (start date of 7/29/13). The current Treatment Administration Record directs staff to offload from wheelchair every hour if resident permitted. Weekly wound flow sheets for R149 were requested but not obtained.

During a staff interview on 12/7/16, at 2:58 p.m. RN-D stated nursing assistants (NAs) were to report off to oncoming NAs at the end of their shift. She further stated there was no written policy or standardized report sheet used for this process. She further stated the NAs reported in Point of Care, but reflected the time it was documented versus the time the resident was repositioned.

On 12/8/16, at 10:54 a.m. the director of nursing stated she expected staff to provide care to residents as directed in their care plans to meet the individual needs of the resident.

The facility's 9/10, Providence Place Pressure Prevention Program Policy and Procedure directed staff to monitor the effectiveness of the pressure ulcer prevention program to reduce the development and progression of pressure ulcers, monitor the incidence and prevalence of pressure ulcers within the facility, and monitor adherences to policies and procedures for consistency in application and conformance with the current standards of practice.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245271	A. BUILDING _____ B. WING _____	C 12/08/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROVIDENCE PLACE	**3720 23RD AVENUE SOUTH MINNEAPOLIS, MN 55407**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 356	Continued From page 9	F 356		
F 356 SS=C	483.35(g)(1)-(4) POSTED NURSE STAFFING INFORMATION 483.35 (g) Nurse Staffing Information (1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law) (C) Certified nurse aides. (iv) Resident census. (2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors.	F 356		1/17/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245271	A. BUILDING _____ B. WING _____	C 12/08/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROVIDENCE PLACE	**3720 23RD AVENUE SOUTH MINNEAPOLIS, MN 55407**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 356	Continued From page 10 (3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. (4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation, document review and interview, the facility failed to post nursing hours in the manner required. This has the potential to affect all residents and visitors. Findings include: Posted nursing hours for public display on 12/5/16, at 11:45 a.m. were dated 12/4/16. On 2/6/16, at 11:30 a.m. the nursing hours posted were dated 12/5/16. On 12/7/16, at 9:45 a.m. the director of nursing (DON) explained that according to the facility's policy, they had until 10:00 a.m. to ensure the hours were posted for the day. They were "in the process" of posting the hours, and later the hours reflected staffing for 12/7/16. In an interview with the staffing coordinator on 12/7/16, at approximately 11:00 a.m. she stated the staff had been posting the hours to reflect the previous day's staffing. The staffing coordinator said she had been told effective that day (12/7/16) she had been informed there was a change in their process, and she was to post the	F 356	1. With respect to posting facility hours; the actual hours worked were completed and posted on 5/24/2016 prior to survey exit. 2. The staffing coordinator received education regarding the requirement for posting the Nursing hours in a timely manner. 3. The guideline for posting nursing hours has been reviewed and revised for implementation. 4. The executive director and/or designee will audit the posting for accuracy and timeliness each week for three months to assure compliance. 5. The data collected will be presented to the QAPI committee by the executive director and/or designee. The data will be reviewed/discussed at the monthly quality assurance meeting. At this time the QAPI committee will make the decision/recommendation regarding any necessary follow up studies.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245271	A. BUILDING _____ B. WING _____	C 12/08/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROVIDENCE PLACE	**3720 23RD AVENUE SOUTH MINNEAPOLIS, MN 55407**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 356	Continued From page 11 current day versus the previous day's staffing.	F 356		
F 412 SS=D	483.55(b)(1)(2)(5) ROUTINE/EMERGENCY DENTAL SERVICES IN NFS (b) Nursing Facilities The facility- (b)(1) Must provide or obtain from an outside resource, in accordance with §483.70(g) of this part, the following dental services to meet the needs of each resident: (i) Routine dental services (to the extent covered under the State plan); and (ii) Emergency dental services; (b)(2) Must, if necessary or if requested, assist the resident- (i) In making appointments; and (ii) By arranging for transportation to and from the dental services locations; (b)(5) Must assist residents who are eligible and wish to participate to apply for reimbursement of dental services as an incurred medical expense under the State plan. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to ensure appropriate dental care for 1 of 3 residents (R123) whose dental status was reviewed. Findings include:	F 412	1. With respect to R123, a dental appointment was scheduled on 12/7/16. 2. All resident records have been audited by health information to ensure they have been offered dental care/services within the past 12 months.	1/17/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245271	A. BUILDING _____ B. WING _____	C 12/08/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROVIDENCE PLACE	**3720 23RD AVENUE SOUTH MINNEAPOLIS, MN 55407**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 412	Continued From page 12 R123 stated in an interview on 12/5/16, at 5:36 p.m. she had missing teeth and needed to see a dentist. She said the facility was made aware of the problem "a while ago," and she was waiting to hear back from them. A dental assessment dated 11/11/16, identified R123 had missing teeth. There was no evidence, however, the resident had been asked if she desired to see a dentist regarding the problem. R123's telephone physician's order dated 8/3/16, revealed the resident was started on an oral antibiotic for "tooth abscess...set up an appointment with a dentist for ASAP [as soon as possible." In addition, Oragel (topical medication for oral pain) was ordered four times daily to the affected tooth. On 8/6/16, a A General Note in R123's medical record read, "Resident is on ABX [antibiotic] for tooth infection." A General Note dated 8/18/16, indicated the resident refused to go to a scheduled dental appointment as she was feeling ill. On 11/6/16, an Oral Dental Note indicated R123 "Allowed oral exam to be completed: Yes. See UDA [dental activity report] for further details regarding teeth, lips, mucosa, gums and mouth pain." On 11/17/16, at a Mini Nutritional Note read, "A mini-nutritional assessment was completed on [R123]...nutritional risk score is 8.0 which indicates at risk of malnutrition...." The health information clerk (HIC)-A explained in an interview on 12/7/16, at 9:35 a.m. R123 had an appointment to see the dentist on 8/8/16.	F 412	3. All health information staff will be re-educated by 1/17/17 regarding the guidelines and process for dental visits and other ancillary services. 4. The director of Nursing and/or designee will complete 2 resident chart audits each week for one month and then 1 resident chart per week for two months to assure dental services are offered and obtained as requested. 5. The data collected will be presented at QAPI be the director of nursing. The data will be reviewed/discussed and decision/recommendations mad regarding any necessary follow up studies.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245271	A. BUILDING _____ B. WING _____	C 12/08/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROVIDENCE PLACE	**3720 23RD AVENUE SOUTH MINNEAPOLIS, MN 55407**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 412	Continued From page 13 Because R123 was ill that day, the appointment had been canceled and had not been rescheduled. Later that day at 12/07/16, at 1:07 p.m. HIC-C said she had set up an appointment that day with Door Stop Dental for R123. She confirmed facility staff made all of R123's appointments and arranged transportation and said she did not know what had happened, but "hopefully she can be seen next week." Registered nurse (RN)-A confirmed R123 was missing teeth during an interview on 12/7/16, at 9:39 a.m. RN-A stated dental assessments were completed quarterly for each resident.	F 412		
F 431 SS=E	483.45(b)(2)(3)(g)(h) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. (a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. (b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who-- (2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and	F 431		1/17/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245271	A. BUILDING _____ B. WING _____	C 12/08/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROVIDENCE PLACE	**3720 23RD AVENUE SOUTH MINNEAPOLIS, MN 55407**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 431	Continued From page 14 (3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. (g) Labeling of Drugs and Biologicals. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. (h) Storage of Drugs and Biologicals. (1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. (2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to maintain medications requiring refrigeration within acceptable temperature ranges in 2 of 5 medication refrigerators, having the potential to affect 11 residents (R44, R289, R207, R290, R21, R123, R288, R199, R149, R212, R141) whose medications were stored at improper	F 431	1. With respect to the identified medications and refrigerators, pharmacy was consulted to determine medications requiring disposal and replacement. The identified refrigerators were checked by maintenance and adjusted to the proper temperature. 2. All medication storage areas have	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245271	A. BUILDING _____ B. WING _____	C 12/08/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROVIDENCE PLACE	**3720 23RD AVENUE SOUTH MINNEAPOLIS, MN 55407**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 431	Continued From page 15 temperatures, and to properly label and/or store medications with shortened expiration dates for 4 residents (R44, R106, R97, R123) whose medications were not labeled when opened and/or were not properly refrigerated when unopened. Findings include: The facility's medication refrigerator log indicated temperatures were to be maintained between 36-46 degrees Fahrenheit (F). The manufacturer's package insert recommendations directed the user to store medications between 36-46 degrees to maintain medication viability and to discard medications that had been frozen. The medication storage system was reviewed on the 2 north (2N) unit on 12/5/16, at 3:49 p.m. with registered nurse (RN)-E. RN-E verified the thermometer registered 32 degrees F (i.e. freezing). RN-E explained, "The night nurse usually checks and records the temperature," and then asked to be excused as his shift had ended. At 3:55 p.m. trained medication aide (TMA)-C then verified medications that were stored in the refrigerator and labeled with current physician orders as follows: R44's gabapentin solution for seizure control and lansoprazole for gastroesophageal reflux both per tube feeding, as well as Levemir and Novolog insulin vials for diabetic control R289's unopened bottle of Acetylcyst sol 20% nebulizer for airway disease R207's Lantus insulin for diabetes control	F 431	been inspected for proper compliance with handling, storage, and dating of opened medications. All medications not in compliance have been disposed of according to facility protocol. 3. Processes and guideline revised for twice daily temperature readings and routine inspection of the medication storage areas for cleanliness, proper storage and disposal. Licensed and trained medication staff on duty for the day and evening shift will be responsible for obtaining readings in their assigned area. All licensed staff and trained medication aids will receive education with return demonstration of thermometer readings and regarding medication expiration and storage guidelines by the DNS/designee. 4. The director of nursing and/or designee will complete daily audits of temperature readings until compliance is assured and then all medication storage areas once weekly to assure proper storage, dating and disposal of expired medications. Duration of auditing determined by sustained compliance. 5. The data collected will be presented at QAPI by the director of nursing. The data will be reviewed/discussed and decisions/recommendations made regarding any necessary follow up studies.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245271	A. BUILDING _____ B. WING _____	C 12/08/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROVIDENCE PLACE	**3720 23RD AVENUE SOUTH MINNEAPOLIS, MN 55407**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 431	Continued From page 16 R290's Levemir and Novolog insulins R21's Novolog and Lantus insulins R123's Novolog insulin per sliding scale per blood sugar testing results In addition, stock medications were stored for potential resident and/or staff that included one vial of tuberculin purified protein derivative (PPD) and one vial of influenza virus vaccine, and an unlabeled vial of Trulicity insulin. The following list of medications were observed in the 3N refrigerator and the contents were verified by RN-H: R288's gabapentin solution and amoxicillin suspension both per gastrostomy tube R199's Vancomycin intravenous antibiotic R149's Novolin insulin R212's pneumovax 23 single injection R141's single injections of Prevnar 13 pneumovax injection as well as Boostrix vaccination booster On 12/5/16, 4:21 p.m. RN-H verified the 3N medication refrigerator temperature registered 48 F, which was above the acceptable range. RN-H stated, "The night nurse is responsible for making sure temperature is correct." On 12/5/16, at 7:11 p.m. during a second check of the temperature of the 2N refrigerator RN-A verified the temperature continued to register at	F 431		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245271	A. BUILDING _____ B. WING _____	C 12/08/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROVIDENCE PLACE	**3720 23RD AVENUE SOUTH MINNEAPOLIS, MN 55407**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 431	Continued From page 17	F 431		

freezing at 32 degrees F. At 7:34 p.m. the nurse consultant also verified temperature in 2N refrigerator registered 32 degrees F.

During an interview on 12/7/16 at 1:00 p.m. RN-B stated "I have worked here for five and a half years. I check the refrigerator temperature once a shift. The normal range is between 36-40 F--I could be wrong. I have to check the correct range on the log."
At 1:05 p.m. RN-A then stated "I check the temperature of the refrigerator once a day. The normal range should be between 36-46. I believe there is a lack of awareness...We need to do staff education."

On 12/7/16, at 1:12 p.m. licensed practical nurse (LPN)-A reported, "I have full access to the medication room. I check the refrigerator at the beginning of my shift. It is supposed to be between 30 and 46. I will adjust the temperature until it comes between the range. If it takes more than two hours to adjust to the correct range, I will call maintenance and the infection control nurse." RN-H was then asked the correct refrigerator temperature range and replied, "I have to be honest--I do not know the exact temperature range, but I will get back to you with that."

The director of nursing stated on 12/8/16, at 12:58 p.m. "I know it is a problem. I expect the staff to monitor every day and ensure the refrigerator is within range on all units. If out of range temperatures are noticed, they should notify the supervisor. The clinical directors are supposed to audit at least weekly." The DON reported she was unaware the refrigerator temperatures had been out of range. The DON said the 2N refrigerator was replaced since the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245271	A. BUILDING _____ B. WING _____	C 12/08/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROVIDENCE PLACE	**3720 23RD AVENUE SOUTH MINNEAPOLIS, MN 55407**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 431	Continued From page 18	F 431		

surveyor's observations.

The director of maintenance (DM) stated on 12/8/16, at 1:54 p.m. "If there are any [maintenance] issues, I tell nursing staff to write on the maintenance board, and I check the log twice a day." The DM said he did not have a record of any staff reporting issues with refrigerator temperatures being out of acceptable ranges, nor had he received any calls related to the problem. He stated he had replaced one refrigerator on the 2N unit following the surveyor's observations as, "It was 32 degrees when I checked on it."

2N refrigerator temperature logs revealed temperatures below 36 degrees in the previous months. December: No data was recorded on 12/1 and 12/2, and on 12/3, 12/4, and on 12/5 it was recorded at 30 degrees. November: Nine days in 11/16 temperatures were missing on the log. Out of range temperatures were recorded at 30 degrees on 11/2, 11/4, 11/11, 11/12, 11/24, and 11/30; 31 degrees on 11/21, 32 degrees on 11/5, 11/7, 11/10 and 11/14, and 34 degrees on 11/6, 11/7, 11/9, 11/10, and 11/18. October: temperatures were not recorded 10 days and were below acceptable ranges (between 30-34 degrees) for 14 days. September: Data was missing on nine days and temperatures were nearly all below normal range at freezing.

3N logs revealed temperatures were not recorded for November: 11/16 and 11/17; October: 10/1 through 10/5, 10/8, 10/16, 10/17, 10/22 though 10/30; September: 9/10, 9/11, 9/18-25, 9/29, and 9/30/16.

The facility's 10/15, Practice Guideline and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245271	A. BUILDING _____ B. WING _____	C 12/08/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROVIDENCE PLACE	**3720 23RD AVENUE SOUTH MINNEAPOLIS, MN 55407**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 431	Continued From page 19 Procedure directed staff to "Monitor and document refrigerator temperatures. Refrigerator temperatures must be maintained between 36 to 46 Fahrenheit." In addition, the facility failed to properly store medications on the 2N medication carts on 12/8/16, at 9:06 a.m. R44's unopened vial of Novolog was stored in the medication cart. RN-E verified the pharmacy label indicated the vial was delivered on 12/6/16, was unopened, and a second nearly full vial of Novolog was also in the cart for R44. RN-E stated the unopened vial should have been stored in the refrigerator, and did not know who had put the medication in the cart versus the refrigerator. RN-E explained opened vials were viable for 28 days after opening. R106's opened and undated Symbicort inhaler was in the cart. RN-E verified it had not been labeled when opened and had 60 uses remaining. The pharmacy label read 11/12/16. RN-E was unsure how long the Symbicort was viable after opening, but said there was a sheet somewhere at the nurses' station indicated time frames for shortened medications. On 12/8/16, at 9:32 a.m. RN-A stated nurses had been made aware of the expiration guidelines for time frames after medications were opened. RN-A stated insulin vials were to be refrigerated until opened. RN-E stated on 12/8/16, at approximately 10:00 a.m. nurses had been trained to date the vials upon opening and were responsible for checking for expired medications when they administered	F 431		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245271	A. BUILDING _____ B. WING _____	C 12/08/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROVIDENCE PLACE	**3720 23RD AVENUE SOUTH MINNEAPOLIS, MN 55407**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 431	Continued From page 20	F 431		

medications and when they cleaned the carts. RN-E had reviewed the medication cleaning schedules, and found no concerns about unlabeled medications the last time she had checked the carts.

On 12/8/16, at 10:26 a.m. RN-G stated unopened new insulin vials were to be refrigerated until they were opened for use, and then were viable for 28 days after opening. RN-G stated she checked expiration dates and they were to be dated upon opening. RN-G explained some inhalers were viable for 30 days and others for three months. RN-G verified three inhalers on cart 2 were opened and undated, including Flovent, Ventolin, and Combivent Reshimat inhalers.

R97's At 10:45 a.m. on 12/8/16, RN-A verified Ventolin inhaler (cart 2) had been opened and had 156 of 200 uses left, but had not been dated when opened.

R123's Flovent inhaler had been opened but was not dated when opened. RN-A verified there were 188 of 200 uses remaining.

In addition, a Symbicort inhaler with an illegible label was stored in the cart, and RN-A said she was "going to toss it."

On 12/8/16, at 9:44 a.m. the DON explained that the Guideline Sheet for medication viability time frame references for the nurses had been missed on the 12/16 medication administration records (MARs). The DON stated when new insulin vials were delivered from the pharmacy, they should have been placed in the refrigerator and then removed for administration, then vials dated and then stored in the medication carts. The DON

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245271	A. BUILDING _____ B. WING _____	C 12/08/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROVIDENCE PLACE	**3720 23RD AVENUE SOUTH MINNEAPOLIS, MN 55407**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 431	Continued From page 21 planned to follow up with the pharmacist to determine if the two vials of insulin needed to be destroyed, and to verify the date the Symbicort had been delivered. The DON stated nurses and TMAs had been trained to date any medications not on a card and were aware of the guidelines provided on the front of the MARs. The facility's 8/15, Medication Storage And Expiration Guidelines from the pharmacy indicated, "Symbicort Inhaler is to be stored at Room Temp [temperature] 3 Months after 1 Use and Date When Open...Specified medications found undated when opened will be presumed to have been opened as of the date of." In addition, unopened vials of insulin were to be stored in the refrigerator until opened then dated and expired 28 days after the first use.	F 431		
F 441 SS=E	483.80(a)(1)(2)(4)(e)(f) INFECTION CONTROL, PREVENT SPREAD, LINENS (a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: (1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards (facility assessment implementation is Phase 2); (2) Written standards, policies, and procedures	F 441		1/17/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245271	A. BUILDING _____ B. WING _____	C 12/08/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROVIDENCE PLACE	**3720 23RD AVENUE SOUTH MINNEAPOLIS, MN 55407**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 22 for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv) When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi) The hand hygiene procedures to be followed by staff involved in direct resident contact. (4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.	F 441		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245271	A. BUILDING _____ B. WING _____	C 12/08/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROVIDENCE PLACE	**3720 23RD AVENUE SOUTH MINNEAPOLIS, MN 55407**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 23 (e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. (f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to follow proper handwashing/infection control for 1 of 2 residents (R91) whose wound care was observed. In addition, the facility failed to ensure proper hand sanitation technique was performed during medication administration for 3 of 10 residents (R37, R91, R234) whose medication administration was observed. Findings include: R91 was asked if he wanted his incontinence brief changed on 12/7/16, at 9:07 a.m. by NA-E and NA-B. R91 replied affirmatively, and the NAs proceeded to assist him with the cares. As the NA wiped R91, a dressing bandage came off his buttocks. RN-D was then apprised of the problem and said she would be in to change R91's dressing. At 9:10 a.m. RN-D entered room washed her hands in the bathroom and gathered supplies. RN-D donned a pair of gloves and cleansed R91's wound and rinsed it with saline. Without removing gloves, cleaning hands and applying clean gloves, RN-D proceeded to apply ointment. Although a second pair of clean gloves were available on the table, they were not utilized by RN-D. The clean bandage was dated and applied to R91's wound. RN-D then removed and threw the gloves in the trash can, gathered the	F 441	1. With regards to the identified employees: Education has been provided regarding hand washing. 2. Infection control reports were reviewed and no trends were identified for any particular group assignment. Staff will be observed for proper hand washing during medication passes and treatments to prevent the transmission of pathogens and possible infection. 3. All nursing staff will receive education for proper technique regarding procedure for hand washing. Education will be completed by 1/17/17. 4. The director of nursing and/or designee will audit two staff each week for one month and then one staff per week for two months to ensure proper hand washing, audits of licensed/trained for medication passes and treatments will be completed 2 per week for one month and then 1 per week for two months. 5. The data collected will be presented to the QAPI committee by the director of nursing. The data will be reviewed reviewed/discussed at the monthly QAPI meeting. At this time the committee will make the recommendation regarding any necessary follow up studies.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245271	A. BUILDING _____ B. WING _____	C 12/08/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROVIDENCE PLACE	**3720 23RD AVENUE SOUTH MINNEAPOLIS, MN 55407**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 24	F 441		

supplies and placed them in a dresser drawer in the room, and left the room without washing her hands.

On 12/7/16, at 9:25 a.m. RN-D stated, "I forgot to change my gloves" between cleansing the wound and applying new dressing. RN-D said, "I was a little nervous."

The following morning at 10:11 a.m the director of nursing stated when dressing changes were performed, nurses should have first washed their hands, donned gloves, removed the old dressing and cleaned the wound. Gloves would then need to be removed, hands re-washed, and clean gloves applied. Ointment would then be used, a new dressing applied, followed by glove removal and hand washing.

The facility's 11/14, Hand Washing policy directed staff as follows: "When conducting a procedure requiring the use of gloves, proper hand washing shall be completed before donning gloves and after removing gloves."

During medication administration observation on 12/5/16, at 5:28 p.m. trained medication aide (TMA)-A reported she was finished passing medications on the 2 south (2S) unit, and needed to go to the third floor to continue passing medication to residents. Upon arriving on the 3 south (3S) unit, she immediately began paging through the medication administration record (MAR) which was located on top of the medication cart (identified as the team one cart). TMA-A took a single medication for R234 and proceeded to the common area the resident was attending an activity, and gave R234 the pill. TMA-A returned to the medication cart and again

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245271	A. BUILDING _____ B. WING _____	C 12/08/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROVIDENCE PLACE	**3720 23RD AVENUE SOUTH MINNEAPOLIS, MN 55407**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 25 paged through the MAR. She then took a single medication from the cart for R37. She then went to the resident's room, but she was not there. TMA-A then returned to the medication cart and states she had finished her medication pass. When asked about sanitizing her hands prior to administering medication to a resident as well as between residents TMA-A reported she had washed her hands "on the other unit" (2S). She further explained she had used the hand sanitizer in the medication cart to disinfect her hands. When asked to view the hand sanitizer on the medication carts, TMA-A was unable to locate the product on either medication cart. TMA-A stated that although she used hand sanitizer when she was on the 2S medication cart, she had failed to clean her hands after arriving on a new unit and prior to administering medication to residents. During an interview on 12/8/16, at 1:11 p.m. registered nurse, (RN)-C stated, "Staff should always sanitize their hands prior medication administration and in between each resident. When staff comes on the unit it is especially important because we do not know what they touched on their way. It is a safety issue for infection control." She explained the policy was to use Purell (instant hand sanitizer containing ethyl alcohol) along with handwashing as the facility's policy stated. On 12/8/16, at 1:27 p.m. a licensed practical nurse, (LPN)-B verified Purell hand sanitizer was not located on the team one cart on 2S. She explained the facility stocked the hand sanitizer as needed and expected it to be available in all medication carts. "We brought two new ones [Purell dispensers] this morning. Our policy is that we can use it up to three times and then we must	F 441		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245271	A. BUILDING _____ B. WING _____	C 12/08/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROVIDENCE PLACE	**3720 23RD AVENUE SOUTH MINNEAPOLIS, MN 55407**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 26 wash our hands with soap and water." R91's medication was set up for administration by RN-A on 12/5/16, at 6:20 p.m. who then gave the medication to the resident in the dining room. RN-A then returned to the medication cart where she proceeded to set up medication for an unknown resident without first washing or sanitizing her hands. RN-A continued the process with another two residents. The surveyor intervened and asked RN-A about hand washing during a medication pass. RN-A reported she would wash her hands "If they were dirty." When asked if she had washed her hands at all during the medication pass she replied, "No--I have not needed to." The medication cart did not contain any available hand sanitizer. RN-A said she could go to the sink if she needed to clean her hands. On 12/8/16, at 11:20 a.m. the RN consultant explained the expectation was for staff to sanitize their hands between resident's medication administration, and were expected to wash their hands if they were visibly soiled. "They should administer the medications, sanitize their hands, and then go on to the next person. " The facility's undated Medication Administration Responsibility Policy and Procedure Manual directed staff to have alcohol based sanitizer available during medication pass and for all employees to wash their hands between tasks. However, the policy did not specifically mention time and technique as to when staff was to sanitize their hands including prior to start of medication administration or between residents.	F 441		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

F5271026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245271	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**12/13/2016**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROVIDENCE PLACE	**3720 23RD AVENUE SOUTH MINNEAPOLIS, MN 55407**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS FIRE SAFETY A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on December 13, 2016. At the time of this survey, Providence Place was found in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. Providence Place is a 3-story building with a full basement. The building was constructed at 2 different times. The original building was constructed in 1984 and was determined to be of Type II(222) construction. In 1995, an addition was constructed to the North side of the building that was determined to be of Type II(222) construction. Because the original building and the addition meet the construction type allowed for existing buildings, the facility was surveyed as one building. The building is fully fire sprinkler protected. The facility has a complete fire alarm system with smoke detection in the corridors and spaces open to the corridor, that is monitored for automatic fire department notification. The facility has a licensed capacity of 181 beds and had a census of 170 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is MET.	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

MDH
Minnesota
Department
of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
December 27, 2016

Mr. Tyler Donahue, Administrator
Providence Place
3720 23rd Avenue South
Minneapolis, Minnesota 55407

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5271028, H5271186, H5271188

Dear Mr. Donahue:

The above facility was surveyed on December 5, 2016 through December 8, 2016 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and to investigate complaint numbers H5271186 and H5271188. that were found to be unsubstantiated. At the time of the survey, the survey team from the Minnesota Department of Health, Health Regulation Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

To assist in complying with the correction order(s), a “suggested method of correction” has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the deficiency within the established time frame is required. The “suggested method of correction” is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm . The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction

order. This column also includes the findings that are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact Gayle Lantto at (651) 201-3794 or email: gayle.lantto@state.mn.us.

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

Please note it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Feel free to contact me if you have questions related to this eNotice.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health

Email: mark.meath@state.mn.us
Telephone: (651) 201-4118
Fax: (651) 215-9697

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00096	A. BUILDING: _____ B. WING _____	C 12/08/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROVIDENCE PLACE	3720 23RD AVENUE SOUTH MINNEAPOLIS, MN 55407

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm The State licensing orders are delineated on the attached Minnesota	2 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00096	A. BUILDING: _____ B. WING _____	C 12/08/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROVIDENCE PLACE	3720 23RD AVENUE SOUTH MINNEAPOLIS, MN 55407

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Continued From page 1 Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. On 12/5/16 through 12/9/16, surveyors of this Department's staff visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed. At the time of the State licensing survey, investigations were conducted into complaints H5271186 and H5271188. The complaints were not substantiated.	2 000		
2 570	MN Rule 4658.0405 Subp. 4 Comprehensive Plan of Care; Revision Subp. 4. Revision. A comprehensive plan of care must be reviewed and revised by an interdisciplinary team that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, with the participation of the resident, the resident's legal guardian or chosen representative at least quarterly and within seven days of the revision of the comprehensive resident assessment required by part 4658.0400, subpart 3, item B.	2 570		1/17/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00096	A. BUILDING: _____ B. WING _____	C 12/08/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROVIDENCE PLACE	3720 23RD AVENUE SOUTH MINNEAPOLIS, MN 55407

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 570	Continued From page 2 This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide care and services to minimize the risk for further development of pressure ulcers for 1 of 2 residents (R149) reviewed with pressure ulcers. Findings include: R149's current care plan for R149 (revised on 2/12/14), indicated the resident had the potential for pressure ulcer development related to immobility, diabetes, incontinence, and sheering. Interventions included turning and repositioning at least every two hours, or more frequently as needed or requested. R149 was observed continuously on 12/7/16, from 12:10 p.m. until 2:48 p.m. without repositioning. At 12:10 he was in a wheelchair in the dining room eating lunch. At 1:04 registered nurse (RN)-I assisted R149 to his room and performed a dressing change as ordered to both feet. At 1:20 an exercise activity was offered to the resident but was declined. At 1:22 RN-I left the room, and no repositioning in the wheelchair was offered or performed during the time RN-I was in R149's room. R149 remained seated in his wheelchair with his eyes closed from 1:28 until 1:53 when the resident's vital signs were taken; the resident was not repositioned. Nursing assistant (NA-C) asked R149 at 2:03 if he needed anything. When asked if he needed his incontinence brief changed or to use the toilet the resident denied being incontinent and replied, "Not now." Repositioning was not offered. At 2:38 RN-I stated there were only two NAs on the floor from 2:30 to 3:00. At 2:44 NA-A stated R149 was not in her "regular group" but she was "covering"	2 570	Acknowledged	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00096	A. BUILDING: _____ B. WING _____	C 12/08/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROVIDENCE PLACE	3720 23RD AVENUE SOUTH MINNEAPOLIS, MN 55407

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 570	Continued From page 3 for NA-B. NA-A stated staff was to offload R149 every two hours, but she was unable to state when R149 had last been repositioned explaining, "I would not know," and stated she did not get a report when she arrived on the unit. At 2:48 R149 remained in his wheelchair without repositioning. During a staff interview on 12/5/16, at 5:10 p.m. the registered nurse (RN-D) stated R149 had developed a pressure ulcer on each of his bilateral (both sides) great toes. She explained the pressure areas were due to edema in his lower extremities and feet which caused his shoes to become tight resulting in pressure, and were unstageable (could not be visualized). A Wound Summary Sheet dated 11/30/16, identified the cause of both the left and the right great toe ulcers as pressure related and facility acquired. R149's most recent Care Assessment Area assessment dated 6/9/16, identified the resident was at risk for skin breakdown due to diagnosis of diabetes, lymphedema, incontinence of bowel and bladder, and immobility. The assessment further indicated R149 did not have skin breakdown at that time. R149's Comprehensive Skin and Positioning Evaluation dated 9/2/16, identified contributing skin factors for the resident including chair fast, skin often moist, very limited mobility, and potential problem for friction and sheer. R149's quarterly Minimum Data Set (MDS) dated 12/1/16, required extensive assistance of two staff for bed mobility and transfers. The MDS indicated the resident had two existing pressure ulcers on his feet. He had pressure relieving devices in the chair and bed, but did not have a turning and repositioning program.	2 570		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00096	A. BUILDING: _____ B. WING _____	C 12/08/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROVIDENCE PLACE	3720 23RD AVENUE SOUTH MINNEAPOLIS, MN 55407

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 570	Continued From page 4 The Active [physician] Orders as of 11/25/16, directed staff to offload (relieve pressure by lifting or standing) from the wheelchair every two hours if the resident permitted (start date of 7/29/13). The current Treatment Administration Record directs staff to offload from wheelchair every hour if resident permitted. Weekly wound flow sheets for R149 were requested but not obtained. During a staff interview on 12/7/16, at 2:58 p.m. RN-D stated nursing assistants (NAs) were to report off to oncoming NAs at the end of their shift. She further stated there was no written policy or standardized report sheet used for this process. She further stated the NAs reported in Point of Care, but reflected the time it was documented versus the time the resident was repositioned. On 12/8/16, at 10:54 a.m. the director of nursing stated she expected staff to provide care to residents as directed in their care plans to meet the individual needs of the resident. The facility's 9/10, Providence Place Pressure Prevention Program Policy and Procedure directed staff to monitor the effectiveness of the pressure ulcer prevention program to reduce the development and progression of pressure ulcers, monitor the incidence and prevalence of pressure ulcers within the facility, and monitor adherences to policies and procedures for consistency in application and conformance with the current standards of practice. SUGGESTED METHOD OF CORRECTION: The DON or designee could review the cares for all residents who require staffs' assistance with repositioning had appropriate care planning	2 570		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00096	A. BUILDING: _____ B. WING _____	C 12/08/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROVIDENCE PLACE	3720 23RD AVENUE SOUTH MINNEAPOLIS, MN 55407

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 570	Continued From page 5 approaches. Nursing staff could be educated and then audits conducted to ensure compliance. The results of the audits could be brought to the quality committee for review. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 570		
2 905	MN Rule 4658.0525 Subp. 4 Rehab - Positioning Subp. 4. Positioning. Residents must be positioned in good body alignment. The position of residents unable to change their own position must be changed at least every two hours, including periods of time after the resident has been put to bed for the night, unless the physician has documented that repositioning every two hours during this time period is unnecessary or the physician has ordered a different interval. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide care and services to minimize the risk for further development of pressure ulcers for 1 of 2 residents (R149) reviewed with pressure ulcers. Findings include: R149 was observed continuously on 12/7/16, from 12:10 p.m. until 2:48 p.m. without repositioning. At 12:10 he was in a wheelchair in the dining room eating lunch. At 1:04 registered nurse (RN)-I assisted R149 to his room and performed a dressing change as ordered to both feet. At 1:20 an exercise activity was offered to the resident but was declined. At 1:22 RN-I left	2 905	Acknowledged	1/17/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00096	A. BUILDING: _____ B. WING _____	C 12/08/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROVIDENCE PLACE	3720 23RD AVENUE SOUTH MINNEAPOLIS, MN 55407

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 905	Continued From page 6	2 905		

the room, and no repositioning in the wheelchair was offered or performed during the time RN-I was in R149's room. R149 remained seated in his wheelchair with his eyes closed from 1:28 until 1:53 when the resident's vital signs were taken; the resident was not repositioned. Nursing assistant (NA-C) asked R149 at 2:03 if he needed anything. When asked if he needed his incontinence brief changed or to use the toilet the resident denied being incontinent and replied, "Not now." Repositioning was not offered. At 2:38 RN-I stated there were only two NAs on the floor from 2:30 to 3:00. At 2:44 NA-A stated R149 was not in her "regular group" but she was "covering" for NA-B. NA-A stated staff was to offload R149 every two hours, but she was unable to state when R149 had last been repositioned explaining, "I would not know," and stated she did not get a report when she arrived on the unit. At 2:48 R149 remained in his wheelchair without repositioning.

During a staff interview on 12/5/16, at 5:10 p.m. the registered nurse (RN-D) stated R149 had developed a pressure ulcer on each of his bilateral (both sides) great toes. She explained the pressure areas were due to edema in his lower extremities and feet which caused his shoes to become tight resulting in pressure, and were unstageable (could not be visualized). A Wound Summary Sheet dated 11/30/16, identified the cause of both the left and the right great toe ulcers as pressure related and facility acquired.

The current care plan for R149 (revised on 2/12/14), indicated the resident had the potential for pressure ulcer development related to immobility, diabetes, incontinence, and sheering. Interventions included turning and repositioning at least every two hours, or more frequently as needed or requested.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00096	A. BUILDING: _____ B. WING _____	C 12/08/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROVIDENCE PLACE	3720 23RD AVENUE SOUTH MINNEAPOLIS, MN 55407

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 905	Continued From page 7 R149's most recent Care Assessment Area assessment dated 6/9/16, identified the resident was at risk for skin breakdown due to diagnosis of diabetes, lymphedema, incontinence of bowel and bladder, and immobility. The assessment further indicated R149 did not have skin breakdown at that time. R149's Comprehensive Skin and Positioning Evaluation dated 9/2/16, identified contributing skin factors for the resident including chair fast, skin often moist, very limited mobility, and potential problem for friction and sheer. R149's quarterly Minimum Data Set (MDS) dated 12/1/16, required extensive assistance of two staff for bed mobility and transfers. The MDS indicated the resident had two existing pressure ulcers on his feet. He had pressure relieving devices in the chair and bed, but did not have a turning and repositioning program. The Active [physician] Orders as of 11/25/16, directed staff to offload (relieve pressure by lifting or standing) from the wheelchair every two hours if the resident permitted (start date of 7/29/13). The current Treatment Administration Record directs staff to offload from wheelchair every hour if resident permitted. Weekly wound flow sheets for R149 were requested but not obtained. During a staff interview on 12/7/16, at 2:58 p.m. RN-D stated nursing assistants (NAs) were to report off to oncoming NAs at the end of their shift. She further stated there was no written policy or standardized report sheet used for this process. She further stated the NAs reported in Point of Care, but reflected the time it was documented versus the time the resident was	2 905		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00096	A. BUILDING: _____ B. WING _____	C 12/08/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROVIDENCE PLACE	3720 23RD AVENUE SOUTH MINNEAPOLIS, MN 55407

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 905	Continued From page 8 repositioned. On 12/8/16, at 10:54 a.m. the director of nursing stated she expected staff to provide care to residents as directed in their care plans to meet the individual needs of the resident. The facility's 9/10, Providence Place Pressure Prevention Program Policy and Procedure directed staff to monitor the effectiveness of the pressure ulcer prevention program to reduce the development and progression of pressure ulcers, monitor the incidence and prevalence of pressure ulcers within the facility, and monitor adherences to policies and procedures for consistency in application and conformance with the current standards of practice. SUGGESTED METHOD OF CORRECTION: The DON or designee could review the cares for all residents who require staffs' assistance with repositioning. Appropriate staff could be educated and then audits conducted to ensure compliance. The results of the audits could be brought to the quality committee for review. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 905		
21335	MN Rule 4658.0725 Subp. 3 A&B Providing Routine & Emergency Oral Health Ser Subp. 3. Emergency dental services. A. A nursing home must provide, or obtain from an outside resource, emergency dental services to meet the needs of each resident. Emergency dental services include services needed to treat: an episode of acute pain in	21335		1/17/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00096	A. BUILDING: _____ B. WING _____	C 12/08/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROVIDENCE PLACE	3720 23RD AVENUE SOUTH MINNEAPOLIS, MN 55407

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21335	Continued From page 9 teeth, gums, or palate; broken or otherwise damaged teeth; or any other problem of the oral cavity, appropriately treated by a dentist, that requires immediate attention. B. When emergency dental problems arise, a nursing home must contact a dentist within 24 hours, describe the dental problem, and document and implement the dentist's plans and orders. This MN Requirement is not met as evidenced by: Based on observation, interview and record review the facility failed to ensure appropriate dental care for 1 of 3 residents (R123) whose dental status was reviewed. Findings include: R123 stated in an interview on 12/5/16, at 5:36 p.m. she had missing teeth and needed to see a dentist. She said the facility was made aware of the problem "a while ago," and she was waiting to hear back from them. A dental assessment dated 11/11/16, identified R123 had missing teeth. There was no evidence, however, the resident had been asked if she desired to see a dentist regarding the problem. R123's telephone physician's order dated 8/3/16, revealed the resident was started on an oral antibiotic for "tooth abscess...set up an appointment with a dentist for ASAP [as soon as possible." In addition, Oragel (topical medication for oral pain) was ordered four times daily to the affected tooth. On 8/6/16, a A General Note in R123's medical	21335	Acknowledged	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00096	A. BUILDING: _____ B. WING _____	C 12/08/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROVIDENCE PLACE	3720 23RD AVENUE SOUTH MINNEAPOLIS, MN 55407

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21335	Continued From page 10	21335		

record read, "Resident is on ABX [antibiotic] for tooth infection." A General Note dated 8/18/16, indicated the resident refused to go to a scheduled dental appointment as she was feeling ill.

On 11/6/16, an Oral Dental Note indicated R123 "Allowed oral exam to be completed: Yes. See UDA [dental activity report] for further details regarding teeth, lips, mucosa, gums and mouth pain." On 11/17/16, at a Mini Nutritional Note read, "A mini-nutritional assessment was completed on [R123]...nutritional risk score is 8.0 which indicates at risk of malnutrition...."

The health information clerk (HIC)-A explained in an interview on 12/7/16, at 9:35 a.m. R123 had an appointment to see the dentist on 8/8/16. Because R123 was ill that day, the appointment had been canceled and had not been rescheduled. Later that day at 12/07/16, at 1:07 p.m. HIC-C said she had set up an appointment that day with Door Stop Dental for R123. She confirmed facility staff made all of R123's appointments and arranged transportation and said she did not know what had happened, but "hopefully she can be seen next week."

Registered nurse (RN)-A confirmed R123 was missing teeth during an interview on 12/7/16, at 9:39 a.m. RN-A stated dental assessments were completed quarterly for each resident.

SUGGESTED METHOD OF CORRECTION: The DON and HIC could ensure residents who have dental needs have appointments scheduled with a dentist. A system to ensure residents' dental needs are addressed could be devised and audits conducted as appropriate. The results of the audits could be brought to the quality committee

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00096	A. BUILDING: _____ B. WING _____	C 12/08/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROVIDENCE PLACE	3720 23RD AVENUE SOUTH MINNEAPOLIS, MN 55407

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21335	Continued From page 11 for review. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21335		
21375	MN Rule 4658.0800 Subp. 1 Infection Control; Program Subpart 1. Infection control program. A nursing home must establish and maintain an infection control program designed to provide a safe and sanitary environment. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to follow proper handwashing/infection control for 1 of 2 residents (R91) whose wound care was observed. In addition, the facility failed to ensure proper hand sanitation technique was performed during medication administration for 3 of 10 residents (R37, R91, R234) whose medication administration was observed. Findings include: R91 was asked if he wanted his incontinence brief changed on 12/7/16, at 9:07 a.m. by NA-E and NA-B. R91 replied affirmatively, and the NAs proceeded to assist him with the cares. As the NA wiped R91, a dressing bandage came off his buttocks. RN-D was then apprised of the problem and said she would be in to change R91's dressing. At 9:10 a.m. RN-D entered room washed her hands in the bathroom and gathered supplies. RN-D donned a pair of gloves and cleansed R91's wound and rinsed it with saline.	21375	Acknowledged	1/17/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00096	A. BUILDING: _____ B. WING _____	C 12/08/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROVIDENCE PLACE	3720 23RD AVENUE SOUTH MINNEAPOLIS, MN 55407

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21375	Continued From page 12	21375		

Without removing gloves, cleaning hands and applying clean gloves, RN-D proceeded to apply ointment. Although a second pair of clean gloves were available on the table, they were not utilized by RN-D. The clean bandage was dated and applied to R91's wound. RN-D then removed and threw the gloves in the trash can, gathered the supplies and placed them in a dresser drawer in the room, and left the room without washing her hands.

On 12/7/16, at 9:25 a.m. RN-D stated, "I forgot to change my gloves" between cleansing the wound and applying new dressing. RN-D said, "I was a little nervous."

The following morning at 10:11 a.m the director of nursing stated when dressing changes were performed, nurses should have first washed their hands, donned gloves, removed the old dressing and cleaned the wound. Gloves would then need to be removed, hands re-washed, and clean gloves applied. Ointment would then be used, a new dressing applied, followed by glove removal and hand washing.

The facility's 11/14, Hand Washing policy directed staff as follows: "When conducting a procedure requiring the use of gloves, proper hand washing shall be completed before donning gloves and after removing gloves."

During medication administration observation on 12/5/16, at 5:28 p.m. trained medication aide (TMA)-A reported she was finished passing medications on the 2 south (2S) unit, and needed to go to the third floor to continue passing medication to residents. Upon arriving on the 3 south (3S) unit, she immediately began paging through the medication administration record

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00096	A. BUILDING: _____ B. WING _____	C 12/08/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROVIDENCE PLACE	3720 23RD AVENUE SOUTH MINNEAPOLIS, MN 55407

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21375	Continued From page 13	21375		

(MAR) which was located on top of the medication cart (identified as the team one cart). TMA-A took a single medication for R234 and proceeded to the common area the resident was attending an activity, and gave R234 the pill. TMA-A returned to the medication cart and again paged through the MAR. She then took a single medication from the cart for R37. She then went to the resident's room, but she was not there. TMA-A then returned to the medication cart and states she had finished her medication pass. When asked about sanitizing her hands prior to administering medication to a resident as well as between residents TMA-A reported she had washed her hands "on the other unit" (2S). She further explained she had used the hand sanitizer in the medication cart to disinfect her hands. When asked to view the hand sanitizer on the medication carts, TMA-A was unable to locate the product on either medication cart. TMA-A stated that although she used hand sanitizer when she was on the 2S medication cart, she had failed to clean her hands after arriving on a new unit and prior to administering medication to residents.

During an interview on 12/8/16, at 1:11 p.m. registered nurse, (RN)-C stated, "Staff should always sanitize their hands prior medication administration and in between each resident. When staff comes on the unit it is especially important because we do not know what they touched on their way. It is a safety issue for infection control." She explained the policy was to use Purell (instant hand sanitizer containing ethyl alcohol) along with handwashing as the facility's policy stated.

On 12/8/16, at 1:27 p.m. a licensed practical nurse, (LPN)-B verified Purell hand sanitizer was not located on the team one cart on 2S. She

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00096	A. BUILDING: _____ B. WING _____	C 12/08/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROVIDENCE PLACE	3720 23RD AVENUE SOUTH MINNEAPOLIS, MN 55407

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21375	Continued From page 14	21375		

explained the facility stocked the hand sanitizer as needed and expected it to be available in all medication carts. "We brought two new ones [Purell dispensers] this morning. Our policy is that we can use it up to three times and then we must wash our hands with soap and water."

R91's medication was set up for administration by RN-A on 12/5/16, at 6:20 p.m. who then gave the medication to the resident in the dining room. RN-A then returned to the medication cart where she proceeded to set up medication for an unknown resident without first washing or sanitizing her hands. RN-A continued the process with another two residents. The surveyor intervened and asked RN-A about hand washing during a medication pass. RN-A reported she would wash her hands "If they were dirty." When asked if she had washed her hands at all during the medication pass she replied, "No--I have not needed to." The medication cart did not contain any available hand sanitizer. RN-A said she could go to the sink if she needed to clean her hands.

On 12/8/16, at 11:20 a.m. the RN consultant explained the expectation was for staff to sanitize their hands between resident's medication administration, and were expected to wash their hands if they were visibly soiled. "They should administer the medications, sanitize their hands, and then go on to the next person. "

The facility's undated Medication Administration Responsibility Policy and Procedure Manual directed staff to have alcohol based sanitizer available during medication pass and for all employees to wash their hands between tasks. However, the policy did not specifically mention time and technique as to when staff was to sanitize their hands including prior to start of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00096	A. BUILDING: _____ B. WING _____	C 12/08/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROVIDENCE PLACE	3720 23RD AVENUE SOUTH MINNEAPOLIS, MN 55407

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21375	Continued From page 15 medication administration or between residents. SUGGESTED METHOD OF CORRECTION: The DON and infection control prevention nurse could review infection control policies and ensure staff are educated. Return demonstration or other auditing could be conducted and the results of the brought to the quality committee for review. TIME PERIOD FOR CORRECTION: Fourteen (14) days.	21375		
21610	MN Rule 4658.1340 Subp. 1 Medicine Cabinet and Preparation Area;Storage Subpart 1. Storage of drugs. A nursing home must store all drugs in locked compartments under proper temperature controls, and permit only authorized nursing personnel to have access to the keys. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to maintain medications requiring refrigeration within acceptable temperature ranges in 2 of 5 medication refrigerators, having the potential to affect 11 residents (R44, R289, R207, R290, R21, R123, R288, R199, R149, R212, R141) whose medications were stored at improper temperatures, and to properly label and/or store medications with shortened expiration dates for 4 residents (R44, R106, R97, R123) whose medications were not labeled when opened and/or were not properly refrigerated when unopened. Findings include:	21610	acknowledged	1/17/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00096	A. BUILDING: _____ B. WING _____	C 12/08/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROVIDENCE PLACE	3720 23RD AVENUE SOUTH MINNEAPOLIS, MN 55407

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21610	Continued From page 16 The facility's medication refrigerator log indicated temperatures were to be maintained between 36-46 degrees Fahrenheit (F). The manufacturer's package insert recommendations directed the user to store medications between 36-46 degrees to maintain medication viability and to discard medications that had been frozen. The medication storage system was reviewed on the 2 north (2N) unit on 12/5/16, at 3:49 p.m. with registered nurse (RN)-E. RN-E verified the thermometer registered 32 degrees F (i.e. freezing). RN-E explained, "The night nurse usually checks and records the temperature," and then asked to be excused as his shift had ended. At 3:55 p.m. trained medication aide (TMA)-C then verified medications that were stored in the refrigerator and labeled with current physician orders as follows: R44's gabapentin solution for seizure control and lansoprazole for gastroesophageal reflux both per tube feeding, as well as Levemir and Novolog insulin vials for diabetic control R289's unopened bottle of Acetylcyst sol 20% nebulizer for airway disease R207's Lantus insulin for diabetes control R290's Levemir and Novolog insulins R21's Novolog and Lantus insulins R123's Novolog insulin per sliding scale per blood sugar testing results In addition, stock medications were stored for potential resident and/or staff that included one	21610		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00096	A. BUILDING: _____ B. WING _____	C 12/08/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROVIDENCE PLACE	3720 23RD AVENUE SOUTH MINNEAPOLIS, MN 55407

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21610	Continued From page 17 vial of tuberculin purified protein derivative (PPD) and one vial of influenza virus vaccine, and an unlabeled vial of Trulicity insulin. The following list of medications were observed in the 3N refrigerator and the contents were verified by RN-H: R288's gabapentin solution and amoxicillin suspension both per gastrostomy tube R199's Vancomycin intravenous antibiotic R149's Novolin insulin R212's Pneumovax 23 single injection R141's single injections of Prevnar 13 Pneumovax injection as well as Boostrix vaccination booster On 12/5/16, 4:21 p.m. RN-H verified the 3N medication refrigerator temperature registered 48 F, which was above the acceptable range. RN-H stated, "The night nurse is responsible for making sure temperature is correct." On 12/5/16, at 7:11 p.m. during a second check of the temperature of the 2N refrigerator RN-A verified the temperature continued to register at freezing at 32 degrees F. At 7:34 p.m. the nurse consultant also verified temperature in 2N refrigerator registered 32 degrees F. During an interview on 12/7/16 at 1:00 p.m. RN-B stated "I have worked here for five and a half years. I check the refrigerator temperature once a shift. The normal range is between 36-40 F--I could be wrong. I have to check the correct range on the log."	21610		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00096	A. BUILDING: _____ B. WING _____	C 12/08/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROVIDENCE PLACE	3720 23RD AVENUE SOUTH MINNEAPOLIS, MN 55407

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21610	Continued From page 18 At 1:05 p.m. RN-A then stated "I check the temperature of the refrigerator once a day. The normal range should be between 36-46. I believe there is a lack of awareness...We need to do staff education." On 12/7/16, at 1:12 p.m. licensed practical nurse (LPN)-A reported, "I have full access to the medication room. I check the refrigerator at the beginning of my shift. It is supposed to be between 30 and 46. I will adjust the temperature until it comes between the range. If it takes more than two hours to adjust to the correct range, I will call maintenance and the infection control nurse." RN-H was then asked the correct refrigerator temperature range and replied, "I have to be honest--I do not know the exact temperature range, but I will get back to you with that." The director of nursing stated on 12/8/16, at 12:58 p.m. "I know it is a problem. I expect the staff to monitor every day and ensure the refrigerator is within range on all units. If out of range temperatures are noticed, they should notify the supervisor. The clinical directors are supposed to audit at least weekly." The DON reported she was unaware the refrigerator temperatures had been out of range. The DON said the 2N refrigerator was replaced since the surveyor's observations. The director of maintenance (DM) stated on 12/8/16, at 1:54 p.m. "If there are any [maintenance] issues, I tell nursing staff to write on the maintenance board, and I check the log twice a day." The DM said he did not have a record of any staff reporting issues with refrigerator temperatures being out of acceptable ranges, nor had he received any calls related to the problem. He stated he had replaced one	21610		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00096	A. BUILDING: _____ B. WING _____	C 12/08/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROVIDENCE PLACE	3720 23RD AVENUE SOUTH MINNEAPOLIS, MN 55407

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21610	Continued From page 19	21610		

refrigerator on the 2N unit following the surveyor's observations as, "It was 32 degrees when I checked on it."

2N refrigerator temperature logs revealed temperatures below 36 degrees in the previous months. December: No data was recorded on 12/1 and 12/2, and on 12/3, 12/4, and on 12/5 it was recorded at 30 degrees. November: Nine days in 11/16 temperatures were missing on the log. Out of range temperatures were recorded at 30 degrees on 11/2, 11/4, 11/11, 11/12, 11/24, and 11/30; 31 degrees on 11/21, 32 degrees on 11/5, 11/7, 11/10 and 11/14, and 34 degrees on 11/6, 11/7, 11/9, 11/10, and 11/18. October: temperatures were not recorded 10 days and were below acceptable ranges (between 30-34 degrees) for 14 days. September: Data was missing on nine days and temperatures were nearly all below normal range at freezing.

3N logs revealed temperatures were not recorded for November: 11/16 and 11/17; October: 10/1 through 10/5, 10/8, 10/16, 10/17, 10/22 though 10/30; September: 9/10, 9/11, 9/18-25, 9/29, and 9/30/16.

The facility's 10/15, Practice Guideline and Procedure directed staff to "Monitor and document refrigerator temperatures. Refrigerator temperatures must be maintained between 36 to 46 Fahrenheit."

In addition, the facility failed to properly store medications on the 2N medication carts on 12/8/16, at 9:06 a.m.

R44's unopened vial of Novolog was stored in the medication cart. RN-E verified the pharmacy label indicated the vial was delivered on 12/6/16, was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00096	A. BUILDING: _____ B. WING _____	C 12/08/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROVIDENCE PLACE	3720 23RD AVENUE SOUTH MINNEAPOLIS, MN 55407

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21610	Continued From page 20	21610		

unopened, and a second nearly full vial of Novolog was also in the cart for R44. RN-E stated the unopened vial should have been stored in the refrigerator, and did not know who had put the medication in the cart versus the refrigerator. RN-E explained opened vials were viable for 28 days after opening.

R106's opened and undated Symbicort inhaler was in the cart. RN-E verified it had not been labeled when opened and had 60 uses remaining. The pharmacy label read 11/12/16. RN-E was unsure how long the Symbicort was viable after opening, but said there was a sheet somewhere at the nurses' station indicated time frames for shortened medications.

On 12/8/16, at 9:32 a.m. RN-A stated nurses had been made aware of the expiration guidelines for time frames after medications were opened. RN-A stated insulin vials were to be refrigerated until opened.

RN-E stated on 12/8/16, at approximately 10:00 a.m. nurses had been trained to date the vials upon opening and were responsible for checking for expired medications when they administered medications and when they cleaned the carts. RN-E had reviewed the medication cleaning schedules, and found no concerns about unlabeled medications the last time she had checked the carts.

On 12/8/16, at 10:26 a.m. RN-G stated unopened new insulin vials were to be refrigerated until they were opened for use, and then were viable for 28 days after opening. RN-G stated she checked expiration dates and they were to be dated upon opening. RN-G explained some inhalers were viable for 30 days and others for three months.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00096	A. BUILDING: _____ B. WING _____	C 12/08/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROVIDENCE PLACE	3720 23RD AVENUE SOUTH MINNEAPOLIS, MN 55407

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21610	Continued From page 21 RN-G verified three inhalers on cart 2 were opened and undated, including Flovent, Ventolin, and Combivent Reshimat inhalers. R97's At 10:45 a.m. on 12/8/16, RN-A verified Ventolin inhaler (cart 2) had been opened and had 156 of 200 uses left, but had not been dated when opened. R123's Flovent inhaler had been opened but was not dated when opened. RN-A verified there were 188 of 200 uses remaining. In addition, a Symbicort inhaler with an illegible label was stored in the cart, and RN-A said she was "going to toss it." On 12/8/16, at 9:44 a.m. the DON explained that the Guideline Sheet for medication viability time frame references for the nurses had been missed on the 12/16 medication administration records (MARs). The DON stated when new insulin vials were delivered from the pharmacy, they should have been placed in the refrigerator and then removed for administration, then vials dated and then stored in the medication carts. The DON planned to follow up with the pharmacist to determine if the two vials of insulin needed to be destroyed, and to verify the date the Symbicort had been delivered. The DON stated nurses and TMAs had been trained to date any medications not on a card and were aware of the guidelines provided on the front of the MARs. The facility's 8/15, Medication Storage And Expiration Guidelines from the pharmacy indicated, "Symbicort Inhaler is to be stored at Room Temp [temperature] 3 Months after 1 Use and Date When Open...Specified medications found undated when opened will be presumed to	21610		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00096	A. BUILDING: _____ B. WING _____	C 12/08/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROVIDENCE PLACE	3720 23RD AVENUE SOUTH MINNEAPOLIS, MN 55407

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21610	Continued From page 22 have been opened as of the date of." In addition, unopened vials of insulin were to be stored in the refrigerator until opened then dated and expired 28 days after the first use. SUGGESTED METHOD OF CORRECTION: The DON and other appropriate staff or consultants such as the pharmacist could review the facility's storage practices to ensure medication viability is maintained at all times. Appropriate staff could be educated as to the importance and system. The refrigerators could be checked to ensure they are able to maintain medications within appropriate temperature ranges at all times. Return demonstrations could be required to ensure appropriate staff understand the temperature ranges and how to read and record temperatures. Audits could be conducted to ensure staff are appropriately checking and reading the thermometers and the results brought to the quality committee for review. TIME PERIOD FOR CORRECTION: Fourteen (14) days.	21610		